

MONTANA LEGISLATIVE HISTORY

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Chapter 349 19 95

Bill H 531 S _____ Original bill & history C

Select

H. Committee on Health

S. Committee on _____

Hearing Date(s) Feb 14 ✓ C

Hearing Date(s) _____ C

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Date Out _____ C

Did this bill originate in an interim committee? Yes No

Committee _____

Report _____

Joint Health Care Select

Mar 07 ✓

Mar 09 ✓

2/18 FISCAL NOTE PRINTED
 2/23 MISSED TRANSMITTAL DEADLINE
 DIED IN COMMITTEE

HB 530 INTRODUCED BY WISEMAN, ET AL.

IMPLEMENT RECOMMENDATION OF THE GOVERNOR'S TASK FORCE TO
 RENEW MONTANA GOVERNMENT BY CREATING AN ALTERNATIVE
 ACCOUNTING METHOD FOR LOCAL GOVERNMENT ENTITIES

2/11	INTRODUCED		
2/11	FIRST READING		
2/11	REFERRED TO LOCAL GOVERNMENT		
2/13	FISCAL NOTE REQUESTED		
2/14	HEARING		
2/15	COMMITTEE REPORT—BILL PASSED AS AMENDED		
2/17	FISCAL NOTE RECEIVED		
2/17	FISCAL NOTE PRINTED		
2/18	2ND READING PASSED	96	2
2/20	3RD READING PASSED	98	2
	TRANSMITTED TO SENATE		
2/21	FIRST READING		
2/21	REFERRED TO LOCAL GOVERNMENT		
3/16	HEARING		
3/20	COMMITTEE REPORT—BILL CONCURRED AS AMENDED		
3/25	2ND READING CONCURRED	48	0
3/27	3RD READING CONCURRED	47	2
	RETURNED TO HOUSE WITH AMENDMENTS		
4/03	2ND READING AMENDMENTS CONCURRED	98	1
4/04	3RD READING AMENDMENTS CONCURRED	99	0
4/06	SIGNED BY SPEAKER		
4/07	SIGNED BY PRESIDENT		
4/10	TRANSMITTED TO GOVERNOR		
4/13	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 430		
	EFFECTIVE DATE: 04/13/95		

HB 531 INTRODUCED BY ORR, ET AL.

PROVIDE FOR THE DESIGN OF CONSUMER REPORT CARDS ON HEALTH
 CARE SERVICES

2/11	INTRODUCED		
2/11	FIRST READING		
2/11	REFERRED TO HEALTH CARE SELECT		
2/13	FISCAL NOTE REQUESTED		
2/14	HEARING		
2/18	FISCAL NOTE RECEIVED		
2/18	FISCAL NOTE PRINTED		
3/04	RREFERRED TO JOINT HEALTH CARE SELECT		
3/07	HEARING		
3/09	HEARING		
3/17	COMMITTEE REPORT—BILL PASSED AS AMENDED		
3/21	2ND READING PASSED	100	0
3/22	3RD READING PASSED	99	1
	TRANSMITTED TO SENATE		
3/23	FIRST READING		

NOTE: ON 3/8, THE SENATE SUSPENDED ITS RULES TO ALLOW THE JOINT
 HEALTH CARE SELECT COMMITTEE TO VOTE AS A BODY RATHER THAN
 A SEPARATE CHAMBER. THUS, HB 531 PROCEEDED DIRECTLY TO 2ND

READING SINCE THIS BILL, WHILE IN THE HOUSE, ALREADY HAD BEEN REPORTED OUT OF THIS COMMITTEE.

3/25	2ND READING CONCUR MOTION FAILED	14	28
3/25	2ND READING INDEFINITELY POSTPONED	27	16
3/27	RECONSIDERED PREVIOUS ACTION AND PLACED ON 2ND READING ON 71ST DAY	40	8
3/29	2ND READING CONCURRED	33	10
3/30	3RD READING CONCURRED	41	9
	RETURNED TO HOUSE		
4/03	SIGNED BY SPEAKER		
4/04	SIGNED BY PRESIDENT		
4/05	TRANSMITTED TO GOVERNOR		
4/10	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 349		
	EFFECTIVE DATE: 10/01/95		

HB 532 INTRODUCED BY TASH, ET AL.
REDEFINE "MENTALLY ILL" FOR PURPOSES OF THE MENTAL ILLNESS
TREATMENT LAW

2/11	INTRODUCED		
2/11	FIRST READING		
2/11	REFERRED TO HUMAN SERVICES & AGING		
2/15	HEARING		
2/15	TABLED IN COMMITTEE		
2/23	MISSED TRANSMITTAL DEADLINE		
	DIED IN COMMITTEE		

HB 533 INTRODUCED BY ARNOTT, ET AL.
PROVIDE FOR PORTABILITY OF HEALTH BENEFIT PLANS BY REQUIRING
INSURERS TO WAIVE CERTAIN TIME PERIODS APPLICABLE TO
PREEXISTING CONDITIONS

2/11	INTRODUCED		
2/11	FIRST READING		
2/11	REFERRED TO HEALTH CARE SELECT		
2/14	HEARING		
2/17	COMMITTEE REPORT—BILL PASSED AS AMENDED		
2/20	2ND READING PASSED	98	1
2/21	3RD READING PASSED	100	0
	TRANSMITTED TO SENATE		
2/27	FIRST READING		
2/27	REFERRED TO BUSINESS & INDUSTRY		
3/06	REFERRED TO JOINT HEALTH CARE SELECT		
3/09	HEARING		
3/18	COMMITTEE REPORT—BILL CONCURRED AS AMENDED		
3/21	FISCAL NOTE REQUESTED		
3/21	2ND READING CONCURRED AS AMENDED	50	0
3/22	3RD READING CONCURRED	49	0
	RETURNED TO HOUSE WITH AMENDMENTS		
3/23	FISCAL NOTE RECEIVED		
4/03	2ND READING AMENDMENTS CONCURRED	98	1
4/04	3RD READING AMENDMENTS CONCURRED	98	0
4/06	SIGNED BY SPEAKER		
4/07	SIGNED BY PRESIDENT		
4/11	TRANSMITTED TO GOVERNOR		
	RETURNED TO HOUSE WITH GOVERNOR'S PROPOSED AMENDMENTS		
4/12	2ND READING GOVERNOR'S AMENDMENTS CONCURRED	97	3

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for HB0531, as introduced

DESCRIPTION OF PROPOSED LEGISLATION:

A bill relating to health care access and cost control; requiring health insurers to offer a basic policy; prescribing minimum requirements for disability insurance; prohibiting the commissioner of insurance from prohibiting certain practices for setting premiums; providing for medical savings accounts; providing for a tax exemption.

ASSUMPTIONS:

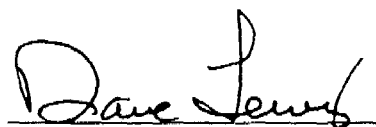
State Auditor's Office:

1. The premium charged to Montana Comprehensive Health Insurance Association (MCHA) participants will decrease from the current level by 25%. The current premium is 200% of the average premium of the five insurers with the largest premium amount of individual major medical insurance in Montana. The bill would lower it by 25%, to 150% of the average premium amount.
2. The increase in benefits is estimated to cause claims to the MCHA plan to increase by an amount between 25% and 30%.
3. The total 1994 premiums were \$1,508,508. The program had an average of 278 participants throughout the year resulting in an average annual premium of \$5,426 per participant.
4. The expected assessment each year, based on comparable experience in other states with programs similar to the MCHA under this bill, is expected to be about 50% of the total premiums received in that year.
5. It is estimated 52% of the MCHA assessment will be deducted dollar for dollar from the premium tax. (43% of the premium is collected by Blue Cross and Blue Shield of Montana, which is exempt from premium tax, and 5% is attributable to other companies who owe no premium tax in any given year.)
6. The combined increase in benefits and the relative decrease in premiums will encourage more participation in the MCHA. Total enrollment will grow from 278 to 834.
7. Assessments by the MCHA are deducted against premium tax due in the year following the assessment. The FY97 general fund revenue will be decreased by FY96 assessments in the estimated amount of \$1,076,636.

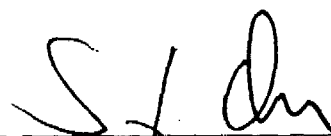
Department of Revenue (MDOR):

8. The income tax-related sections of the bill are effective October 1, 1995.
9. The bill applies to tax years beginning after December 31, 1995.
10. It is assumed that retirees would not use the medical savings accounts.
11. It is assumed that households in poverty would not use the medical savings accounts.
12. The 1993 poverty thresholds (below which households are estimated to be in poverty) are as follows: single person households under age 65, \$7,518; single parent households, \$11,137; and married couple households (with and without children), \$11,631 (U.S. Bureau of the Census and MDOR).

(continued)

 2-18-95

DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning


SCOTT ORR, PRIMARY SPONSOR DATE

Fiscal Note for HB0531, as introduced

HB 531

Department of Revenue (continued):

13. The bill allows deposits in medical savings accounts of up to the total of the amount of health insurance premiums, contract fees, deductible amounts, and copayments required for a health plan with at least a \$1,000 deductible.
14. It is assumed that lower income groups will contribute smaller amounts to medical savings accounts as compared with higher income households.
15. The amount of annual contributions to medical savings accounts is assumed to be the amount of national out-of-pocket health care expenditures by income group published for 1991, adjusted to calendar year 1996 by projected increases in medical costs, and modified for Montana using the ratio of average 1992 out-of-pocket Montana household health expenditures (\$1,133) to estimated 1992 out-of-pocket U.S. household health expenditures (\$1,679) (Consumer Expenditure Survey, 1990-91, U.S. Bureau of Labor Statistics; Wharton Econometric Forecasting Associates for projected medical cost increases; Montana Health Care Authority for Montana out-of-pocket health care expenditures; and U.S. Bureau of the Census for estimated number of households).
16. The amount of assumed contributions to medical savings accounts by participating households by Montana adjusted gross income group is as follows: (1) under \$5,000, \$814 in contributions; (2) \$5,000--\$9,999, \$959 in contributions; (3) \$10,000--\$14,999, \$1,193 in contributions; (4) \$15,000--\$19,999, \$1,257 in contributions; (5) \$20,000--\$29,999, \$1,377 in contributions; (6) \$30,000--\$39,999, \$1,425; (7) \$40,000--\$49,999, \$1,494; and (8) \$50,000 and over, \$1,888 in contributions.
17. If all households participated in the medical savings account program defined in the bill, the negative revenue impact for the individual income tax for tax year 1996 (FY 97) would be \$14.6 million for resident taxpayers (MDOR Income Tax Simulation Model).
18. Even though the bill is written for residents (Section 9), under 15-30-131 (MCA) non-residents are treated as residents. Therefore medical savings accounts are assumed to apply to residents and non-residents alike.
19. An estimated additional six percent of the resident tax impact applies to non-residents, for a total potential negative revenue impact for FY 97 of about \$15.5 million.
20. Not all households will participate in the medical savings account program under this bill. Many households already participate in the current federal flexible medical spending account program (Section 125); some people, particularly young adults, are simply very healthy and need very minimal health care; some households just above the poverty line go without health care because they cannot afford it; and many households do not use government programs because of lack of information.
21. Even though many households would not participate in this program, the proportion of participating households will be higher than otherwise, since Section 10(6) of this legislation provides for tax-free withdrawals of account balances above \$10,000 for non-medical related payments. These payments are: (1) payment for post-secondary education for the employee or account holder or for someone in the immediate family of that individual; (2) first-time purchase of a single-family home by the employee or account holder; and (3) investment in an individual retirement account, or in a federally defined cafeteria plan, including flexible medical and other spending accounts.
22. It is assumed that 40 percent of households will use this program in tax year 1996, yielding a negative revenue impact of roughly \$6.2 million.
23. In order to implement the bill, the Department of Revenue would require 1.00 additional grade 11 FTE; a line would need to be added to the individual income tax return with related programming and other data processing costs; and additional equipment would be necessary.

(continued)

FISCAL IMPACT:Department of Revenue:Expenditures:

	<u>FY96</u>	<u>FY97</u>
	<u>Difference</u>	<u>Difference</u>
FTE	0.50	1.00
Personal Services	12,509	25,104
Operating Expenses	10,885	3,340
Equipment	<u>6,589</u>	<u>0</u>
Total	29,983	28,444
<u>Funding:</u>		
General Fund (01)	29,983	28,444

Revenues:

Individual income tax (01)	0	(6,200,000)
Insurance premium tax (01)	0	(1,076,636)

Net Impact on General Fund Balance:

General Fund (cost) (01)	(29,983)	(7,305,080)
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LONG-RANGE EFFECTS OF PROPOSED LEGISLATION:

Future increases or decreases in participation in the MCHA will impact general fund revenues accordingly.

Health insurance premiums and other health care costs may increase over time. Because these increases are likely and assuming increased participation in medical savings accounts, it is possible that the negative revenue impact of medical savings accounts will increase in the long-term.

TECHNICAL NOTE:

Sections 10 (6) and 10 (7) of the bill may be in conflict. Section 10 (6) specifies that withdrawals for certain purposes will not be taxed, while section 10 (7) refers back to section 10 (6) and specifies that these withdrawals are taxable.

Alberta to come to the United States, which affects the quality and availability of health care in that Province. Dr. Gorsuch stated that this is not an isolated event and indicated a stack of notebooks about two feet tall "filled with over 1,000 articles detailing from 1989 to 1994 some of the problems in the Canadian health care system." He read excerpts from a February 1989 article in MacLeans, "the Canadian equivalent to our Time Magazine," detailing many of the problems and shortages in the Canadian health care system. He stated, "that while we have problems in our system, the problems of the Canadian system are not our solution."

Arlette Randash, representing Eagle Forum, and on behalf of Laurie Koutnik for the Christian Coalition, opposed the Single Payer Plan "because we have seen the danger to human life; not only for the unborn, but for the infirm, the handicapped and the elderly." She said, "the Montana Health Care Authority, I believe, has definitively said that it is not financially feasible." She urged a Do Not Pass for HB 548. She said, "we applaud the efforts of those who are bringing forth incremental efforts to address health care problems. [REPS.] TOM NELSON, ROYAL JOHNSON, SCOTT ORR, PEGGY ARNOTT all have bills up that we're going to be hearing and we applaud their efforts to protect human life in those measures."

Questions From Committee Members and Responses: None.

Closing by Sponsor:

REP. CAREY closed by thanking the committee for a good hearing and stated that the proponents spoke from the point of view of the consumers, and the opponents spoke generally from the point of view of the insurance industry. He said, "We need to take a look at that dichotomy." He stated that when "they talk about increased taxes, they're not talking about the benefits that would flow from the Single Payer system." REP. CAREY read excerpts from the Health Care Authority's report of October 1, 1994, page 39. (Refer to Exhibit 6, cited earlier) He said, "I submit to you that the Health Care Authority has documented the rational basis for us promoting the Single Payer Plan and I therefore would draw your attention to the fact that when they talk about increased taxes we need to talk about increased benefits. . . . I hope as legislators, we're not scared away by anecdotal references, in fact very misguided references, to the HCA's work." He urged the Committee to give HB 548 a realistic consideration.

{Tape: 2; Side: 1}

HEARING ON HB 531

CHAIRMAN ORR relinquished the chair to VICE-CHAIRMAN CARLEY TUSS so he could present this bill as sponsor.

Opening Statement by Sponsor:

REP. SCOTT ORR, House District 82, Libby, Montana, sponsored HB 531, known as the "Heal Montana bill," and the "Medi-Choice bill." He stated that many portions of this bill are duplicative; it includes portability, renewability, preexisting conditions and medical savings account. REP. ORR stated that HB 531 is unique in that there are some portions that deal with disclosures of premium history, disclosures of doctors' charges, and public disclosures of hospital charges.

Proponents' Testimony:

Paul Gorsuch, representing Project Heal, Great Falls, Montana, spoke in support of HB 531. He stated that the ideas to this bill were first presented in response to the question of what was meant by market-oriented reform. "Since then we've maintained the basic ideas of that first inquiry although the proposal has been characterized in a number of different ways by different participators in the debate." He urged the Committee not to look at those characterizations, but to look at the substance of the bill. Insurance should be renewable; the sick should not be singled out and dropped from coverage, or the insurance rates increased to the point of being forced out of the market. Mr. Gorsuch stated that this bill resolves that problem and makes insurance renewable. Insurance should be affordable and remain affordable when changing jobs. High-risk individuals have difficulty finding health coverage. This bill provides a package for high-risk individuals which is affordable for most and definitely a better benefit than is available to them now. This bill contains Medical Savings Accounts which would spur accountability, responsibility, and a healthy motivation to look at the costs of health care services. When proposing a market-oriented system, it's essential to have price information. Without price information, or if price information is only available to large groups, the individual has little chance for competing or finding cost-effective services. This bill solves that problem by making price information available to everyone. EXHIBIT 14

Ed Grogan, representing the Montana Medical Benefit Plan, the Montana Medical Benefit Trust, the Montana Business Health and Alliance, said that HB 531 is an extremely good bill. It guarantees portability and renewability for all Montanans. It makes good health insurance accessible to everyone. It holds both insurers and providers accountable by requiring full disclosure of policies and prices. And finally, through the use of Medical Savings Accounts it addresses the affordability problem. EXHIBIT 15

Mike Schweitzer, M.D., representing Billings Anesthesiology, P.C., Billings, Montana, spoke in support of HB 531. EXHIBIT 16

Rob Hunter, masters degree in health administration, and has worked in the field of health benefits and managed health care for the past ten years, spoke in support of HB 531. EXHIBIT 17

Arlene Reichert, Great Falls, Montana, a former Democratic legislator and a Constitutional Convention Delegate, spoke in support of Medi-Choice legislation.

Dr. Cheryl Reichert, Pathologist, Director of the Laboratory, McLaughlin Research Institute, Great Falls, Montana, spoke in support of HB 531. She said that "most folks in Montana talk about the last best place with the emphasis on best. For the purposes of this brief discussion, I'd like to emphasize last. Because by being a little bit behind the times we have the opportunity to profit from both the successes and failures of what's happened elsewhere; and possibly to make a detour." She stated that the complexities of health care boil down to one point, and that is of control. Dr. Reichert said, "Whoever pays for health care is going to control the system. Would it be a governmental bureaucracy with all of its inefficiencies? ...that's not what I want for my family. Not that inefficiency. Not that over-utilization that comes with the illusion that health care is free. Would it be a mega-monopoly of business people; something that I fear even more." This has happened in other markets where doctors are being delisted because they spent too much time with the patient, or don't order enough tests. And doctors were rewarded for spending less money on their patients. "That's not the kind of system that I want." She stated that control should belong to the individual. Dr. Reichert said, "health care shouldn't be that much different from other kinds of services. We need to arm the public and the patients with information that will allow them choice and control. The Medical Savings Plan is one way to start them on that path. It's your choice. We hope it'll be Medi-Choice." EXHIBIT 18

Cari Reichert, owner of Image Concepts, an advertising and graphic design firm in Missoula, Montana, spoke in support of Medi-Choice. She has studied the plan and personally named the plan. She provided brochures for which she donated her time to name the plan, give it a slogan and design the logo. EXHIBIT 19 She said, "The fundamental principal behind Medi-Choice is the freedom to choose. To choose what hospitals I go to, what doctors I go to, and which insurance carriers I choose to use. I want a plan that is based on free market reform, one that is driven by competition, quality and value. Let's remodel our health care system through Medi-Choice."

John Heetderks, physician, Bozeman, Montana, urged the Committee to adopt HB 531. He said Medi-Choice is a fine bill. It is the result of a lot of time and effort by some very good people, who have looked at this plan carefully. This plan is being adopted by other states. Dr. Heetderks indicated that his father was an old-fashioned country doctor, who served his patients in the Gallatin valley for 51 years. During the Great Depression, his

father cared for his patients whether or not they could pay him for his services. "His unselfish care was appreciated. People paid what they could; sometimes with cash, but often with pies, cakes, potatoes and chickens. Many couldn't pay him anything. But they trusted my father. There were no lawsuits, even though he wasn't perfect and made mistakes in his patient care. I was privileged to work with my dad in our medical practice in Bozeman for 15 years before he died. . . . Together we span 77 years of patient care. I'm in my 40th year of medical practice. As our society has gradually decayed, so has health care." Dr.

Heetderks shared some of the vast and tragic changes in doctor-patient relationship and health care delivery. Firstly, there has been a progressive loss of the patient's free choice in selection of a personal physician. This is to be accelerated by the White House managed care plans and Medicare. He added that Medicare has become the model for health insurance underwriters. He stated that patient recovery from illness or injury is critical to the trust relationship between the patient and physician. Secondly, **Dr. Heetderks** stated that patients have been robbed of personal responsibility for their own health care. Many patients exercise no responsibility for the cost or quality of their health care. Too frequently they go to the emergency room when they could have gone to their physician's office. "Why not go to the emergency room they say; after all, they're not paying the bill and have no concern about who pays the bill. They have no sense of responsibility about expense of their health care." This drives health care costs up. **Dr. Heetderks** said the adoption of Medi-Choice will result in less cost to the government, to the taxpayer, and even to the patient. Better health care will result; care which both the patient and their physician participate in.

Elizabeth Reichelt, Great Falls, Montana, spoke in support of HB 531 for all the reasons previously stated because "I believe in the benefits to all Montanans." She stated that both her husband and herself are both self-employed, both in their forties, and both uninsurable due to previous existing conditions. She stated that she has been unable to find insurance that would allow out-of-pocket payment for coverage of preexisting conditions and cover catastrophic illnesses. "We are currently covered for the next 12 months through a COBRA plan from my former employer. After that a catastrophic illness, heart disease or cancer could wipe out everything that we have built over all these years." She strongly urged the Committee to pass the Medi-Choice plan.

Kent Merselis, a self-employed real estate developer and consultant, Bozeman, Montana, stated that skyrocketing premiums have gotten out of control. He stated that one reason he left industrial relations to become a self-employed individual was because of the high cost of employee health care premiums. He said, "I'm concerned not only about myself, but for my children. . . . Will they be able to afford health care when they have their own families ten years from now?" He stated that any plan which encourages tax free savings accounts to be established for

payment of minimal medical expenses will quickly do away with the evasive attitude that prevails in the United States regarding medical bills for auto insurance. That is to "let the other guy pay for it. Madam Chairperson, I am the other guy. And I'm tired of paying the penalty." He urged the Committee to enact HB 531. He said, "If we can pass this bill, it'll do away with millions of dollars that go in to support the medical insurance staff" for the shuffling of paper for minor claims.

Jerome Loendorf, representing the Montana Medical Association, stated that "this bill could be presented as several bills and I'd just like to say if it was, we'd support each one of them." He commented on the provision in HB 531 which provides for a basic health care plan. He stated that plan set forth would draw some arguments and differences. He said, "The key thing to remember here is this plan is not the only plan an insurer can offer. An insurer is required to offer this plan, but can offer any other plans that it believes it can market in this state." He commented on the provision which would require doctors to disclose their charges to people who requested them. He said, "we have to recognize that if we want the system to change, we have to be part of the change and except changes proposed by others."

Raymond Fowler, M.D., Anesthesiologist, Great Falls, Montana, commented that many physicians will be testifying. "When you look at physician support for this bill, I'd like to make it clear that physicians have often been accused of being very self-serving and doing what's in their own best interests in respect to their pocketbooks. I'd like to point out that if this Medi-Choice plan is enacted, which I strongly support...it's going to result in the very judicious use of medical services and in some way will probably result in decreased financial revenues for most physicians because patients will be more careful in their utilization of medical services. The conclusion here is that all of the physicians that support this bill are doing so against their own financial interests."

Dr. Peter Horst, Urologist, Great Falls, Montana, stated that because of child care needs in 1991, he had hired a 53-year-old woman with a history of Crohn's disease to provide full-time care for his daughter. As a benefit, Dr. Horst, provided health care insurance which cost \$325 a month with a \$500 deductible. She had previously been part of a group insurance plan in Colorado, and the only insurance that she could get was as a single person. He indicated that her premiums first increased to \$375 at which point her deductible was increased to \$1000; and then her premiums increased to \$397 with a \$2000 deductible in four years. Over those four years, she's never had a claim that would have been paid for by her health care insurance. She's had no hospitalizations. She did have some neurological problems last year which resulted in about \$1500 worth of studies, none of which were covered by her health care insurance. He indicated that if Medi-Choice were in action four years ago, she would have

had money accumulated into her medical IRA which would have paid for her outpatient radiographic studies for neurologic symptoms, and she would have a reasonable deductible and reasonable premium. He said, "I support this bill."

Ron Kunik, insurance agent since 1981, founded the Montana Business and Health Alliance, the Montana Medical Benefit Plan, stated that HB 531 comes closest to true reform. He stated that HB 531 gives health insurance accessibility to all Montanans. He stated that Montana Medical is the only insurer here testifying for this. He indicated that if HB 531 is passed, then amendment of SB 285 should be repealed. EXHIBIT 20

John Mendenhall, self-employed businessman, Great Falls, Montana, strongly supported HB 531. He stated that the other plans "seem to be increasingly convoluted complex efforts to thwart the immensely powerful invisible hand of the marketplace, and I think the events of the past 30 to 40 years ought to teach us a little respect for the power of the marketplace."

Tamela Vander Aarde, M.D., Anesthesiologist, Great Falls, Montana, urged the Committee to support HB 531. She said it is a well thought out bill that enjoys grassroots support and she stated that it represents true reform. EXHIBIT 21

Dr. Jeanne Garcia, Great Falls, Montana, spoke in support of HB 531 with the following amendment: "to increase inpatient mental health benefits from 14 inpatient days to 21 inpatient days, and also increase the yearly maximum to \$11,000."

Richard Tappe, Executive Director of the Montana Right to Life Association, urged the Committee's support for HB 531. He stated that reform is necessary. He said, "HB 531 does preserve genuine choice and gives people in the market the opportunity to determine what's going to happen in our health care system in Montana."

Dean Randash, NAPA Auto Parts, a small business employer in Helena, Montana, spoke in support of HB 531. EXHIBIT 22

Robert Wynia, a native Montanan, born in Plentywood and grew up in Poplar, and spent the last 32 years in Great Falls, Montana. He stated that he had the privilege of serving on the Committee that has studied the Medi-Choice bill for the past two years. "We've met every week [and] we have measured the pros and cons ... to the point that we feel that we have covered most of the basic problems and we request your support of HB 531."

John Vandenacre, representing himself, an insurance agent since 1978, stated that as an agent, the most common objection to purchasing a health insurance plan is the cost. He indicated that the Small Employer Group Health Reform Act compounds that problem rather than alleviating it. "Medi-Choice...goes a long way toward addressing the affordability without penalizing a

small segment of society such as the Small Employer Reform Act does." He urged the Committee's support for HB 531.

Shirley Rasmussen, Stevensville, Montana, stated that she has personally created her own family medical savings account 12 years ago. She said, "it works; the system that is within this plan does work exactly the way that they wanted it to, and that you become more involved with the health of your own family and your own responsibility." She stated that significantly decreased her dependence on the doctor. Her account had been used twice in 12 years with six children. EXHIBIT 23

Allen Lanning, Attorney, Great Falls, Montana, spoke in support of HB 531 on behalf of himself, his family, his business, and his employees. He said, "this is the best piece of health care reform proposal I've seen yet, and I urge you to support it."

J. R. Chipman, President of Benefit Innovations, Missoula, Montana, spoke in support of HB 531.

Jay McKean, retired farmer, Roberts, Montana, spoke in support of HB 531.

Ray Gowen, retired engineer, Great Falls, Montana, spoke in support of HB 531.

David Owen, Montana Chamber of Commerce, specifically endorsed the Medi-Save portion of the bill.

Arlette Randash, representing Eagle Forum, and on behalf of Christian Coalition of Montana for Laurie Koutnik, spoke in support of HB 531.

Susan Good, representing Heal Montana, spoke in support of HB 531.

Opponents' Testimony:

Tanya Ask, representing Blue Cross Blue Shield of Montana (BCBS), stated that the primary concern is that this is not necessarily true comprehensive reform of the insurance industry. She indicated that six of the eight items addressed by this bill, however, do address insurance reform. She stated firstly, that this proposal does not have guaranteed issue of insurance coverage, like the Small Group Reform Bill does. She reminded the Committee that New Section 2 through 6 applies not only to individual, but to group insurance. EXHIBIT 24

Ms. Ask commented that the basic benefits plan (page 3) has a high level of deductible, however, the level of co-insurance included in this basic plan is 80%. She stated that a number of insurance contracts written in Montana have a lower level of co-insurance allowing more individual responsibility such as 75-25

or 70-30, where the individual is responsible for maybe 30% of their health care expenses.

Ms. Ask advised that when considering basic, also consider that particular amount. **Ms. Ask** commented on covered expenses dealing with usual and customary charges, page 3, line 21. She inquired if this would require an insurance company to pay usual, customary and reasonable? "What about insurance companies, or health service corporations, or HMOs who might reimburse on a different system, such as the capitation system, recognizing that things are changing within the insurance industry as well? Would those still be allowed?"

Ms. Ask questioned the scheduled list of benefits for transplants on page 4 because certain dollar amounts are specifically included. She indicated that medical technology is changing very rapidly; the types of transplants that people receive change rapidly and these dollar amounts may not apply in two years. "There may be things that will be transplanted in two years that we have not even contemplated." She urged not including scheduled benefits in legislation. She stated that HB 531 attempts to cover mental illness and chemical dependency, but mental retardation has also been included as an illness; it is not an illness.

Ms. Ask indicated that on page 5 there are a number of services specifically excluded in statute. She questioned the wisdom of specifically excluding services in statute. One exclusion in particular, on page 7, is the exclusion for complications to a newborn unless no other source of coverage is available. Under all other health insurance in Montana "newborn coverage is a required benefit; here you are specifically excluding that coverage, but it would be included for every other insurance coverage."

Ms. Ask commented on the preexisting waiting period on page 6; as it is written an individual could meet three months and then have no preexisting waiting period any longer. She indicated that most insurance contracts require 12 months. "The idea of portability is once you've met your 12 months then you don't have to meet another preexisting waiting period." **Ms. Ask** questioned the 45-day written notice of the health insurer in the event the individual has not paid their health insurance premiums, page 6. She stated that the individual is covered during those 45 days and emphasized that this is free coverage. She stated this is not free. "It's free to the individual here, but somebody else is going to pay the tab, and that is the rest of us who are covered by health insurance."

Ms. Ask questioned subsection 4, page 7, allowing an individual employee the opportunity to choose to remain on their former employers health insurance contract even though they work for a new employer who offers health insurance. She indicated that this may pose a problem. **Ms. Ask** questioned the conversion cap

of 150% of the average premium being charged by the five largest insurers in the state of Montana (page 7).

{Tape: 2; Side: 2; Comments: Tanya Ask, BCBS of Montana is testifying.}

She indicated that some may write only catastrophic, other carriers may write a very rich level of benefits. She stated that 150% of that average could be very problematic. **Ms. Ask** commented on modifying the time period an insurance company can look back when determining preexisting conditions (page 8). "Under current law it is now five years. Under this particular provision it would be only 24 months." However, the way this provision is written it would only "apply to Yellowstone Community Health Plan of HMO, and Blue Cross Blue Shield of Montana. What about the commercial carriers?"

Ms. Ask referred to page 9 and stated that New Section 5--"the commissioner not to prohibit premiums based on loss ratio guarantee"--needs clarification as it is unclear what this provision is meant to address. **Ms. Ask** commented on the standardized claim form, New Section 6, page 9. She agreed that there needs to be more administrative simplification, that there does need to be a standardized claim form and standardized procedures for filing those claim forms. However, this particular provision does not allow for standardized claim form for hospital services, the UB92. It does not allow a standardized claim form for dental services.

Ms. Ask stated probably the biggest problem deals with the expansion of the Comprehensive Health Care Association (CHCA). She indicated that the CHCA was established by this legislature to deal with individuals who could not get coverage otherwise in the individual market. It was meant to be an insurer of last resort. She stated that the CHCA is a state program which is subsidized by the state and by insurance companies. The CHCA would be expanded under this proposal; more people would be covered, premiums would be capped at 150% making it more affordable to some. "But, who pays for it? The answer is those people who have individual and small group coverage... because it is subsidized through an assessment against all insurance companies doing business in this state according to the premium volume they write." She stated that large employers are able to self-insure, thus avoiding this particular type of assessment and this type of program. "It is again being borne on the back of a few." **Ms. Ask** questioned the fining capability in the event that information is not disclosed. She stated that more information needs to be made available to health consumers. She stated that "the fine for insurance companies is \$1000 and we found it interesting that the fine for providers is \$500."

Mona Jamison, representing the Montana Speech, Language, and Hearing Association comprised of Speech Pathologists and Audiologists, and representing the Montana Dietetic Association comprised of Nutritionists, opposed the basic plan and the

specifics contained on pages 3 and 4 of HB 531. She provided amendments. **EXHIBIT 25** She spoke about the failure to include nutrition services, speech pathology and audiology services in the basic plan. She stated that these services not only prevent further disease, but also provide cost containment. She indicated that the services listed under these amendments would require that it be under a case management plan with the therapy required by the referring physician. She stated that these services are not very expensive and affect some of the other diseases listed. **Ms. Jamison** indicated that this is the only section of HB 531 that she opposed. She said, "I believe if these amendments are made it will be a better basic plan dealing with the needs of individuals."

John Flink, representing the Montana Hospital Association, spoke in opposition to HB 531, Section 18. **EXHIBIT 26**

Tom Hopgood, representing the Health Insurance Association of America, which is composed of the other half of the insurance market not represented by BCBS, stated that he agreed with the comments made by **Tanya Ask** from BCBS. **Mr. Hopgood** commented on page 6, subsection 2. He understands it to mean that you don't have to comply with the preexisting condition in a policy if at any time you have had some sort of qualifying coverage. I don't think this was intended. He commented on "dumping uninsurable people into the comprehensive risk pool under the Montana Comprehensive Health Association." He indicated that this may result in some discrimination problems, perhaps under the American Disabilities Act.

David Hemion, representing the Mental Health Association of Montana, opposed HB 531. He commented on the benefits dealing with mental retardation on pages 4 and 19. He questioned the inclusion of mental retardation with the benefits for mental illness and chemical dependency. **Mr. Hemion** suggested amending this as 21 days of hospitalization for mental illness and chemical dependency ... with no annual cap on that benefit. As in **REP. NELSON'S** bill that there be a two to one trade for partial hospitalization, that there be a \$2000 annual outpatient benefit. He suggested that mental retardation not be included in that same benefit section and if it is to be included in the plan to be included separately.

Marty Onishuk, Vice President for the Montana Alliance for the Mentally Ill, stated that mental illnesses are brain diseases and in this bill they are discriminated against because they are pulled out separately than other brain diseases like Alzheimer's, Parkinson's, epilepsy and multiple sclerosis.

Larry Akey, representing Montana Association of Life Underwriters, and on behalf of the Independent Insurance Agents of Montana, stated that a number of provisions contained in **REP. ORR'S** bill are good provisions and commented on several of the sections within HB 531, concerning benefit design considerations,

the cap on premium rates on conversions. Mr. Akey said that placing caps on the provision of medical services would be appropriate because that's where the real cost-drivers are. Insurance premiums are the symptom of the underlying costs.

Mr. Akey stated that REP. ORR'S approach in addressing preexisting conditions in HB 446 is much better than the approach taken in HB 531. He suggested removing the preexisting condition provisions from HB 531, and amending it with the preexisting condition provisions of HB 446. He stated that like others in the insurance industry, "we're not sure exactly what Section 5 means." There is concern that if companies start using loss ratio guarantees as the basis directly or indirectly for determining premiums on individual policies, the whole mechanism of insurance would be lost, which is the pooling of risks. He commented on Medical Savings Accounts, and changes in the Montana Comprehensive Health Association plan.

Mr. Akey commented on pricing data and stated that it is important to provide price information to customers. He raised a concern about the wording and stated that he was unclear about the process for fining an agent \$500, how it will be determined if, in fact, the agent received the information from the insurance carrier, who will make the determination, and how it will be addressed. He urged the Committee to give HB 531 a Do Not Pass recommendation.

Mary McCue, representing the Montana Clinical Mental Health Counselors Association (MCMHCA), an association of licensed professional counselors, spoke in opposition to HB 531. She stated that she had the same concerns as expressed by David Hemion. She said the association supports the benefit scheme for mental health that is contained in REP. TOM NELSON'S bill and SEN. CHRISTIAENS' bill. She indicated that the MCMHCA had worked on the coverage for mental health with insurers and other providers groups for the past two years.

Tom Bilodeau, Research Director of the Montana Education Association, opposed HB 531.

Unknown author, written testimony, EXHIBIT 27

Questions From Committee Members and Responses:

REP. BEVERLY BARNHART inquired about Medicaid in the working core.

CHAIRMAN ORR deferred the question to the lobbyist.

VICE CHAIRMAN TUSS inquired of REP. BARNHART if her question dealt specifically with HB 531.

REP. BARNHART indicated that she was unsure. However, it was in the packet and mentioned "Medicaid in the working core and that we will be getting another bill."

VICE CHAIRMAN TUSS inquired as to which bill this information references.

Susan Good stated that the bill references REP. ROGER DEBRUYCKER'S bill from last evening.

REP. RICHARD SIMPKINS stated his concern that hospitals don't wish to provide pricing information, and inquired what the problem is in standardizing the information to be provided in one location.

Mr. Flink replied that the hospital's position has supported greater disclosure of consumer information. [Some of his comments were not audible on the tape.]

REP. SIMPKINS clarified that hospitals do not object to providing data, but that the hospitals don't know which data is to be collected and in what format.

Mr. Flink answered that they would endorse the collection of meaningful data.

REP. SIMPKINS requested clarification of the figures on preexisting conditions.

Mr. Akey indicated that some amendments would be presented for preexisting conditions.

REP. TOM NELSON indicated page 1, line 19 through line 24 about any group or blanket policy. He inquired if this bill only applies to individual insurance.

David Niss replied that he did not think that was the intent, and suggested discussing that further.

Closing by Sponsor:

CHAIRMAN ORR stated that HB 531 is primarily a product of the work that Heal Montana/Project '94 has been doing for the last two years. He stated that many of the questions brought out by the opponents had been addressed just in the last couple of days since this came out of drafting. He indicated that the majority of those will be in amendments for Executive Action. In closing, REP. ORR said, "this is market-based reform and I would ask for your passage."

VICE CHAIRMAN TUSS turned back the chair to CHAIRMAN ORR.

HOUSE OF REPRESENTATIVES

Select Committee on Health Care

ROLL CALL

DATE 2-14-95

NAME	PRESENT	ABSENT	EXCUSED
Rep. Scott Orr, Chairman	✓		
Rep. Carley Tuss, Vice Chairman	✓		
Rep. Beverly Barnhart	✓		
Rep. John Johnson	✓		
Rep. Royal Johnson	✓		
Rep. Betty Lou Kasten			✓
Rep. Tom Nelson	✓		
Rep. Bruce Simon	✓		
Rep. Dick Simpkins	✓		
Rep. Liz Smith	✓		
Rep. Carolyn Squires	✓		

DATE Feb. 14, 1995
HB 531
Paul Gorsuch

**HEAL
MONTANA**

The Montana
Health Education
Alliance

Volume 95, Issue 2-January 1995

MEDI★CHOICE

The Plan YOU Choose

The original of this document is stored at
the Historical Society at 225 North Roberts
Street, Helena, MT 59620-1201. The phone
number is 444-2694.

(unbound report)

Current Status
of the
HEAL Montana
Health Reform
Proposal

P.O. Box 111
Great Falls, MT
59403

(800) 720-3181

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EXHIBIT 15
DATE Feb. 14, 1995
HB 531

MONTANA BUSINESS & HEALTH ALLIANCE

*Over 2300 members statewide
founded in 1989 by Montanans to provide low cost
health benefits for small Montana businesses and individuals*

P.O. Box 548
Kalispell, Montana 59903-0548
(406) 756-3444

NOTES FOR PRESENTATION ON PROJECT HEAL BILL HB531

HURRAY! FINALLY I HAVE THE OPPORTUNITY TO BE VERY POSITIVE ABOUT SOMETHING!! HB 531 IS A GIANT STEP IN THE RIGHT DIRECTION IF WHAT WE'RE AFTER IS FREE MARKET REFORM OF OUR HEALTHCARE SYSTEM!

IN THE RECENT PAST I HAVE HEARD STATE AUDITOR MARK O'KEEFE STATE THAT INSURANCE REFORM IS NOT ALL THAT IS NEEDED AND IS ONLY PART OF THE HEALTH CARE REFORM EQUATION. WE AGREE!!

HB 531 IS A GIANT INCREMENTAL STEP TOWARD HEALTH CARE REFORM! IT CONTAINS INSURANCE REFORM THAT GUARANTEES PORTABILITY AND RENEWABILITY FOR ALL MONTANANS. IT MAKES GOOD HEALTH INSURANCE ACCESSIBLE TO EVERYONE. IT HOLDS BOTH INSURERS AND PROVIDERS ACCOUNTABLE BY REQUIRING FULL DISCLOSURE OF POLICIES AND PRICES. AND FINALLY, THROUGH THE USE OF MEDICAL SAVINGS ACCOUNTS IT ADDRESSES THE AFFORDABILITY PROBLEM.

I STRONGLY URGE YOU TO PASS HB 531, AND BECAUSE THERE IS NO FURTHER NEED FOR SMALL GROUP REFORM AFTER YOU PASS THIS BILL, I ALSO STRONGLY URGE YOU TO PASS REPRESENTATIVE LIZ SMITH'S HB 155 WHICH REPEALS THE AMENDMENT.

THANK YOU FOR THIS OPPORTUNITY TO TESTIFY.

ED GROGAN

Billings Anesthesiology, P.C.

Mike Schweitzer, M.D. Pres.

David Khoe, M.D. V. Pres.

Steve Kriner, D.O. Sec-Treas.

Bruce Coan, M.D.

David Daines, M.D.

Brian Harrington, M.D.

P.O. Box 1859

Billings, MT 59103

(406) 259-1686

Rod Lee, M.D.

Brian McGuire, M.D.

Tom Robinson, M.D.

Paula Roos, M.D.

Nancy Sweeney, M.D.

Marvin Warren, M.D.

2/13/95

Representative Scott Orr
Chairman - MT House Select Committee on Health Care
Capitol Station
Helena, MT 59620

Dear Chairman Orr and Members of the Committee :

We offer our support for HB 531. We feel strongly that this health system reform will benefit our families, our patients, and those we work with every day. We urge you to pass this Bill.

We enthusiastically support the concepts of insurance portability, renewability, and simplification of insurance processing forms. Tax equity for health insurance enhances the ability of individuals and small businesses to afford health insurance premiums. This will increase the number of Montanans who have health insurance all year long.

Medical Savings Accounts would reduce the cost of insurance and expenditures for routine medical needs dramatically if insurance were used only for major medical expenses. The current tax law for income set aside in a tax-exempt account for medical expenses encourages a "use it or lose it" approach. This approach increases demand for medical services and costs when we should be promoting savings and efficient use of the health care system.

Amending the Montana Comprehensive Health Insurance Association Plan would expand the benefits for Montanans with pre-existing or high-risk illnesses. Currently the premiums are too high and the benefits too low.

Pricing information on insurance companies, hospitals, and physicians will help consumers evaluate their health care purchases. This is essential to promote value-conscious behavior and personal responsibility.

Please give deliberate consideration and support to this important Bill which could significantly reduce the costs of health care for most Montanans. Thank you.

Sincerely,



Mike Schweitzer, M.D.
President

DATE Feb. 14, 1995

HB 531

Testimony in favor of HB 531

Madam

☒ Chair~~man~~, members of the Committee, ^{for the record} my name is Rob Hunter, and I am testifying as a proponent of the MediChoice Plan, HB 531. Before stating my reasons for encouraging you to support ~~it~~ ^{HB 531} I think it is important that that I briefly describe my experience, not to draw attention to myself but rather so that the members will appreciate the perspective I have on this matter.

☒ minimize

I have a masters degree in health administration, and for the past ten years have worked in the field of health benefits and managed health care. I have assisted in the development of an HMO, and have some experience in virtually every function of this type of managed care organization. I have been involved in or personally directed the development of numerous preferred provider arrangements in the Pacific Northwest, have managed a third party administration firm, have developed and managed a utilization management and case management program, have developed a small group health insurance program, have assisted in the development of a community based purchasing coalition, have assisted in the development of four managed care organizations for management of workers compensation cases, have participated in a public process to reform small group health insurance, and over the past two years in my capacity as an independent consultant have assisted various employers, insurers and providers in ~~various~~ programs and endeavors to control healthcare cost and quality. In other words, I have a work-a-day familiarity with market-based health care reforms.

During the past several years, particularly as the healthcare reform debate heated up, I wondered if anyone could or would design a plan for reform which was based on incentives rather than penalties, which would be more of a carrot and less of a stick. We know from experience that the market responds rapidly to carrots - look at the growth of self-funding under ERISA preemption over the past 20 years, and particularly the last 10. It has exploded, and whether one likes ERISA preemption or not, there is no arguing the fact that the market loves it and has prospered under it.

I can tell you that it is relatively easy, even and perhaps especially with very good intentions, to design reforms that are coercive and choice reducing, although it is obviously more difficult to ~~persuade affected parties to subject themselves to such~~ ^{implement} reforms. Conversely, I was not optimistic that any of us working alone or together would be able to design a plan for reform which would infuse the health care finance system with real market-based economics and incentives. And then I was introduced to MediChoice.

~~to that would be based on carrots and not~~
☒ I heard several people comment over the past two years that the sponsors of MediChoice were anti-reform. They clearly were not supportive of many of the reforms which were then under serious consideration. But I wonder if we were unable to appreciate a true market based reform because our perception had been developed in a debate that was dominated by an abundance of what we might call "big stick" reforms.

and
 rather
 than
 wielding
 a stick.

You will hear much better descriptions of the details MediChoice than I could offer from others here today. I am therefore going to confine my comments to a brief comparison or two and to address potential arguments against the bill. ~~My comparisons will be based on an alternative reform that is close at hand, which is my only reason for referring to it.~~

delete from original

Several weeks ago I stood before this Committee to argue for repeal of the small employer health availability act. My comments were not offered without appreciation for some of the finer points of the Act, like portability, guaranteed renewability, and the assurance that persons with genetic or congenital diseases or healthcare problems could not be refused access to coverage. My position was based on my opinion that the Act would be inflationary, that the Act's admission that it failed to address affordability was not a badge of honor but rather a critical defect which over time would reduce access. By contrast, MediChoice directly and I think very effectively addresses the affordability issue by increasing the consumers' responsibility for his or her purchase choices. That is the essence of market-based reform.

The Availability Act further forced most small insurers out of our market because it required them to assume the same risks as large insurers but on a much smaller income base. This result is analogous to a statutory requirement that small banks issue loans with as much risk as any loan a large bank might issue, and is as threatening to the policyholders of small insurers as this type of banking reform would be to depositors at small banks. MediChoice, by comparison, does not attempt to manipulate the insurance market, but rather is designed to expand market choices.

If I was going to argue against MediChoice I might choose to list shortcomings which, though they may only be technicalities, given enough volume might distract you from the bottom line ~~reform~~ ^{performance}. I have not consulted with the sponsors in the development of this plan, and so I do not stand here to testify that it is either technically pure or in need of immediate amendment. I only want to remind you that it is headed in the right direction and like any other bill passed by this legislature will be perfected over time.

Another ~~line of attack~~ ^{charge} might be that without federal deductibility the plan is seriously deficient and won't work. That is ~~the~~ arguing that no carrot is better than anything except the biggest carrot. The plan surely would have a greater impact if supported by federal deductibility, but it will definitely have some favorable net effect with the State deduction alone.

Finally, one might argue that the plan for improving and expanding the Comprehensive Health Association as the last resort for coverage is a plan for creating a second class citizenry when it comes to health insurance. We need to remember that we have a second class right now called the uninsured. What MediChoice does is improve the lot of these persons by providing affordable, good value coverage that is not presently available to many of them through the Association plan or otherwise. ~~I might add that the Association plan, as modified by MediChoice, would not represent a reduction in coverage for a number of people I know who are presently covered in the private sector.~~

EXHIBIT 17

DATE 2-14-95

~~HB 531~~

MediChoice is not the final solution, but it is the beginning of a very promising solution. I
my years of working in the field and both watching and participating in the reform debate I
have seen no other reform as promising as this. I offer this endorsement with full
recognition that if it is as successful as I ~~hope~~ ^{sure of} it will be, it could reduce the need for my
consulting services. I might have some regrets, but Montanans in general will not - please
support HB 531.

*about that. But this Committee, the
legislature*

10-2-94

From the readers' advocate *Great Falls Tribune*

Here is my advice on medicine...

For the past three months, I have served as the readers' advocate on the Tribune Editorial Board. It's been a rewarding experience, and I now have a much better appreciation for the challenges of journalists. I was invited to join the editors to provide a local physician's perspective into health system reform, and now that my rotation is completed, I was asked to share a few parting thoughts.

Our health care delivery system is undergoing the most rapid and comprehensive change within our lifetime, and decisions made today will affect medical services for generations to come. While there is a temporary "time-out" at the national level, this process of restructuring will continue with the 1995 Montana Legislature and locally through a series of deliberations studying the consolidation of the Columbus Hospital and the Montana Deaconess Medical Center.

Although those who currently have access to health care are generally pleased by the quality of services, there is a consensus of opinion that the economic basis of our health care system is in need of reform. In addition, better access is needed for those who would like to be insured but can't afford the premiums. Unacceptably high health care costs have bankrupted individuals and made the products of American corporations less competitive in the global marketplace.

No one would set out to design our present patchwork system of health care, with insurance coverage that drops patients with pre-existing conditions when they change jobs, hospitals that shift costs from under-compensated government programs to the private sector and from outpatients to inpatients, complex billing claims that generate a blizzard of mostly unintelligible paperwork, governmental agencies that employ an army of over-zealous inspectors and bureaucrats seeking to justify their existence, and hovering malpractice attorneys whose very presence encourages the costly defensive practice of medicine.

Although the specifics of health system reform are incredibly complex, the underlying philosophical issue is readily



GUEST COLUMN
Cheryl Reichert

understood — whoever pays the tab will control the service. Given the government's track record of inefficiency, high costs, and the predictable over-utilization of services that are perceived to be free, a government-run single payer system is unlikely to provide the high quality, responsive care that many Americans have come to expect. I find the alternative of government-legislated business monopolies even less palatable, inasmuch as this profit-motivated system is designed to reduce access to specialists and provide fewer diagnostic tests, resulting in delayed therapeutic interventions. At risk are the trusting, long-term relationships between doctors and patients, replaced by impersonal "doc-in-the-box" interactions with interchangeable providers.

There is another alternative that guarantees that individuals and families will be given the right to choose which doctor, which insurance carrier, and which hospital best suits their needs. Free-market reform will provide consumers with the knowledge and incentives to make prudent health care decisions. Part of these goals can be accomplished through tax-exempt individual medical savings accounts or through vouchers for the medically uninsured. These "medi-save" accounts are to be supplemented with renewable, portable, high deductible catastrophic private health insurance. Because medisave accounts accrue to the individual, frivolous expenditures are

discouraged. Patients could be financially rewarded for certain cost-effective preventive health care measures, such as vaccinations and prenatal visits.

In order that the market force of competition can preserve quality and control costs, patients would be granted access to information about fees and about other treatment options. Billing claims would be standardized and simplified. Through a choice of private health insurance plans, individuals (not governments or businesses) would be able to determine in advance of illness how aggressive the treatment options should be in sustaining life.

During the past 18 months Great Falls based "Project Heal Montana" has been working on such a "medi-choice" alternative, in the hopes that this proposal will be seriously debated during the upcoming state legislative session. This plan will require some latitude from the federal and state governments in granting tax-exemptions for "medi-save" accounts and a willingness on the part of Montanans to experiment with a system that is based upon the old-fashioned principles of individual and family responsibility.

Over many decades, Great Falls has evolved into a rather extraordinary medical community, and no one wants to jeopardize the good in trying to create the better. We cannot take a hatchet to our present health care system and expect to end up with anything that is functional, let alone improved. We are fortunate in Montana that we suffer from less of the social pathology (drugs, violence, AIDS) that has precipitated the health cost crisis in other parts of the country.

It is my hope that health system reform in Montana will proceed in an incremental and logical manner and at a measured pace. Before we make irrevocable changes, we would be wise to profit from the successes and failures of other states and other communities that have already begun this process.

Dr. Cheryl M. Reichert is director of pathology at the Columbus Hospital, 500 15th Ave. S., and a board member of Project Heal Montana.

EXHIBIT 18
DATE Feb. 14, 1995
HB 531

- consideration of empowering locally-controlled bodies to accredit hospitals and eliminate excessive paper work burdens imposed by national organizations.

4. Expanded Benefits for High-Risk

Individuals: Even though Montana has a mechanism for insuring people with preexisting or high-risk illnesses, the premiums are too high and the benefits are poor. Medi•Choice would expand the benefits and increase the subsidy for the current Montana Comprehensive Health Plan. How much to spend in doing this should be arrived at in open debate.

5. Pricing Information: Medi•Choice would establish a clearinghouse to make available and easily understandable the pricing information for insurance, hospitalization and doctors' fees. This is essential to promote value-conscious behavior and personal responsibility.

Such information—including cost comparisons among hospitals—would be publicly available and would help eliminate price gouging.

6. Medicaid: If allowed by the federal government, experimental programs could be implemented in the state that could provide insurance for recipients rather than the state acting as a single payer to manage recipient care.

*The Medi•Choice approach
means health insurance for all
without employer mandates,
price controls, state rationing
and forced health care alliances*

Your Support is Needed

Project HEAL Montana plans to introduce Medi•Choice during the 1995 Legislative Session. To accomplish this goal, we will be:

- conducting an intensive lobbying campaign at the Legislature
- implementing a state-wide public relations effort
- soliciting more membership and grassroots support
- developing additional support for Medi•Choice by networking with other organizations
- conducting a top-quality actuarial analysis of Medi•Choice
- bringing to Montana nationally known experts in health care to help promote Medi•Choice
- Setting up telephone trees to reach our supporters quickly with timely information

But time is short. As we go to press, to hall meetings promoting government care of health care are happening throughout Montana.



Project HEAL Montana is a non-profit educational organization dedicated to achieving reforms in health care that will

ensure high-quality health care services while preserving individual freedom of choice within a free-market system.

Members of Project HEAL Montana represent a wide cross section of Montanans including health care professionals, politicians, business people, concerned citizens, ranchers, farmers, and others.

We have developed a comprehensive health system reform plan for Montana that we are taking to the Legislature as an alternative to the proposals currently being examined.

P.O. Box 111
Great Falls, Montana 59403

1-800-720-3181

Our Philosophy

A good health care system should, as much as possible, promote individual independence and responsibility while exercising the compassion we all need.

We should avoid the quick fix of establishing government agencies to

ilate our health system. Despite the best
ntions of many good people, government
ncies are limited by the inherent fault of
bureaucracies—centralized decision-
king. This process robs individuals of the
ver and right to make their own health
e choices.

astic reform measures like the single-
yer or multi-payer systems take
mendous risks that have the potential for
evocable disasters.

Health is not achieved in a day. Improving
r health system should be a continuing
ocess keeping what is good and improving
on the rest.

*...good system will be compassionate toward
people, subsidize the less fortunate and
prevent financial ruin from severe health
problems while retaining freedom of choice.*

Within those bounds, people should pay the
real cost of what they get in medical care and
health insurance.

Our health care system should give
individuals incentives and responsibilities to
be healthy, to make their own health choices
and be value conscious. Every Montanan
must retain the freedom to contract with a
doctor, hospital or other health care provider
of his or her choice and on his or her terms.

Without freedom of choice, there can be only
a growing dependency on government
along with ever-rising costs. The economic
burden to the people of Montana for the
expansion of the welfare state is a burden we
cannot afford.

- Renewable, portable and tax deductible health insurance
- Progressive State Health Credits
- Medical Savings Accounts (MSA)
- Simplification through standardized insurance billing and claims clearinghouses
- Expanded benefits for the current Comprehensive Health Plan for high-risk individuals
- Clearinghouse of price information for insurance, hospitalization and doctor fees

1. Insurance: All health insurance should be renewable and portable. Medi•Choice would eliminate “job lock” and guarantee uninterrupted access to health insurance for all Montanans. The same renewability and portability would be extended to dependents.

With Medi•Choice, insurance premiums would be completely tax deductible for everyone.

Progressive Health Credits would be available to those who:

- don't qualify for Medicaid
- are too poor to finance their own health insurance
- have expenses too high to pay.

To supplement the individual's own funds, the state would subsidize them with a voucher system or tax credit. This approach means health insurance for all *without* employer mandates, price controls, state rationing and forced health care alliances. Increased costs here would be offset partially by diminished cost shifting as more families acquire health insurance and health

of insurance and expenditures for routine medical needs would drop dramatically if insurance were used only for major medical expenses. Medi•Choice incorporates the establishment of tax-free savings accounts for routine expenses.

Current tax law permits employees to set aside income in a tax-exempt account to be used for medical expenses, but these funds must be used by the end of the year or forfeited. This “use it or lose it” feature increases demand for medical services and costs when we should be promoting savings and value. Medi•Choice would require changes to the tax code to allow these funds to roll over or would establish new tax codes to create medical savings accounts.

Most people who currently pay for health insurance could fund an MSA with the premium savings achieved by purchasing low-cost, high-deductible policies rather than the more expensive low-deductible policies. Those having high-deductible policies already would be able to fund an MSA from the savings of fully tax-deductible premiums. Those who are supported or supplemented by the state would achieve their accounts by channeling the state funding to their MSAs.

3. Simplification: Medi•Choice would simplify the management system and reduce costs through:

- standardized insurance billing
- electronic claims submission
- claims clearinghouse
- medical debit cards to draw on MSAs

EXHIBIT 20
DATE Feb. 14, 1995
HB 531
Ron Kunik

SUGGESTED AMENDMENTS TO
HB 466 SPONSOR, TOM NELSON
HB 531 SPONSOR, SCOTT ORR

AMEND 33-22-1811

(4) Add (C)

An insurer can elect not to insure a group if that group is already insured.
However, the insurer must decline or accept the whole group that is currently insured.

EXHIBIT 21 Page 1 of 2
DATE Feb. 14, 1995
HB 531

Yamela Vander Aarde MD
1006 1st Av. S.
Great Falls, MT 59403

Chairman Scott Orr,
House Select Committee on HealthCare
Capitol Building
Helena, MT 59620

Dear Chairman Orr,

I am writing to urge you and your committee to support HB 531. I feel that it is a well thought out piece of legislation that will make health insurance more available to Montanans making it possible for them to avoid financial ruin due to health problems while retaining their freedom of choice. I am in favor of renewable, portable health insurance which this bill requires. It seems to me that when one makes the choice to devote some of their resources to purchasing health insurance they should not lose that choice because their life or career circumstances later change. I also think that medical savings accounts are an excellent idea whose time has come. There are many self employed people in our state who would benefit from this provision.

Medical savings accounts allow self-employed people to pay for medical expenses and health insurance premiums with pre-tax dollars just as people who work for employers are already able to do. Medical savings accounts create

EXHIBIT 21, Page 2 of 2
DATE Feb. 14, 1995
HB 531

incentives to save rather than spend, to become informed consumers of health care and to engage in healthy lifestyles with an eye toward disease prevention. All of this reduces health care costs while maintaining freedom of choice. Finally, the bill provides for making price information from licensed providers, hospitals and health insurers available to consumers upon request. I realize that this may have a negative financial on me but I am willing to go along with it as part of the package. I urge your strong support of this bill in its entirety.

Sincerely,

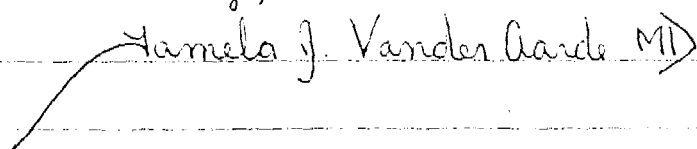
 Pamela J. Vander Aarde MD

EXHIBIT 22
DATE Feb. 14, 1995
HB. 531

HB-531 - Representative Scott Orr

February 14, 1995

Dean M. Randash - NAPA Auto Parts

I stand in complete support of HB-531. I thank the sponsor and authors for addressing true "Insurance Reform" in such an indiscriminate and just manor. Insurance reform of this magnitude and scope that addresses all these vital Areas of concern while respecting the integrity of life, the individual is profound.

Upon passage of this true "Insurance Reform" legislation I look forward to working with the employees of NAPA Auto Parts in building a "PEACE OF MIND" group health insurance program. The tools in this insurance tool kit, HB-531, will empower each and every employee to be able to attain affordable health insurance coverage for their families. The flexibility will be a tremendous incentive to accomplish increased family insurance coverage.

Please DO PASS HB-531

EXHIBIT 23

DATE Feb. 14, 1995

HB 531

- 14 - 95

Mr. Chairman

My statement is only this, I have personally created for myself and those for whom I am responsible for, for ^{health} insurance coverage, a Medical Savings Account.

Twelve years ago when Blue Cross raised my insurance rates to a point higher than I could pay, I was able to purchase coverage from another Co. We chose a ~~he~~ in spite of being diagnosed with a mitral valve. We chose a \$1000 deductible plan. I knew I would be responsible to pay for all my minor medical expenses. I knew I had to have a way to cover that expense, should the need arise. ^{with} great effort ^{at that time I was receiving \$500.00} I saved my deductible and continued saving until I had saved the co-insurance.

Over these 12 years this plan has worked very well.

My personal health maintenance my personal health maintenance

I have with drawn from that account only to pay medical expenses - 2 times in 12 years -

I am here to say M.S.A. work - People can take care of themselves - We do not need government to pay our bills for us - For ultimately governments ability to pay is contingent upon the ability of you and I to pay enough premiums and taxes -

Health insurance is not a right belonging to everyone and paid for by government - I am not an insurance agent, nor a medical person - I am an individual ~~with a medical insurance~~ ~~does not cost \$14,000 a year -~~

diagnosis that makes me uninsurable - my insurance does not cost \$14,000 a year - If yours does, I suggest to look far and find the company I found -

I am a farmer and small Business
person. Ask me if the health
care crisis is over and I will
give a resounding "yes"! It
never did start as some
would have you believe.

Don't think for one minute
the cost of premiums will go
down with a single payer
plan!

You have had statements from
powerful organizations and companies -
that would have you believe a
single payer plan would give
better coverage more efficiently -
I believe the only way that
would come together is to mandate
coverage - when it is LAW to
carry insurance, it is only
another tax - It looks to me
like taxes have gone up faster
than insurance premiums -

Urgen urge you to pass
531 and repeal SB285
777-3062 - Shirley Rasmussen
Staunsville Mt.

1--Loss Ratio Guarantee option

Rates on a particular individual health insurance policy form shall be deemed reasonable in relation to the premium and shall be deemed approved upon filing with the Commissioner which meets the requirements of this act. Benefits shall continue to be deemed reasonable in relation to the premium so long as the insurer complies with the terms of the loss ratio guarantee. This loss ratio guarantee must be in writing, signed by an officer on the insurer, and must contain at least the following:

(A) A recitation of the anticipated loss ratio standards contained in the original actuarial memorandum filed with the policy form when it was originally approved.

(B) A guarantee that the actual loss ratios in the State for the experience period in which the new rates take effect and for each experience period thereafter until new rates are filed shall meet or exceed the loss ratio standards referred to in subparagraph (A) above. If the annual earned premium volume in this State under the particular policy form is less than \$1,000,000 and therefore not actuarially credible, the loss ratio guarantees shall be based on the actual nationwide loss ratio for the policy form. If the aggregate earned premium for all states is less than \$1,000,000, the experience period shall be extended until the end of the calendar year in which \$1,000,000 earned premium is attained.

(C) A guarantee that the actual loss ratio results for the State (or national results, if applicable) for the experience period at issue shall be independently audited at the insurer's expense. This audit must be done in the second quarter of the year following the end of the experience period and the audited results must be reported to the Commissioner not later than June 30 following the date for filing the applicable Accident and Health Policy Experience Exhibit.

(D) A guarantee that if the actual loss ratio during an experience period is less than the anticipated loss ratio for that period, then policy holders in this State shall receive a proportional refund based on premium earned. The total amount of the refund will be calculated by multiplying the anticipated loss ratio by the applicable earned premium during the experience period and subtracting from that result the actual incurred claims during the experience period. If nationwide loss ratios are used, then the total amount refunded in this State shall equal the total refund, as calculated above, multiplied by the total earned premium during the experience period from all policyholders in this State who are eligible for refunds and divided by the total earned premium during that period in all states on the policy form.

The refund shall be made to all policyholders in this State who are insured under the applicable policy form as of the last day of the experience period and whose refund would equal \$10.00 or more. The refund will include interest, at the then-current accident and health reserve interest rate established by the National Association of Insurance Commissioners, from the end of the experience period until the date of payment. Payment must be made during the third quarter of the year following the experience period for which a refund is determined to be due.

(E) A guarantee that refunds of less than \$10.00 will be aggregated by the insurer and paid to the Insurance Department of this State.

(F) As used herein, the term "loss ratio" means the ratio of incurred claims to earned premium by the number of years of policy duration, for all combined durations.

(G) As used herein, the term "experience period" means, for any given rate filing for which a loss ratio guarantee is made, the period beginning of the first day of the calendar year during which the rates first take effect and ending on the last day of the calendar year during which the insurer earns \$1,000,000 in premium on the form in question is this

State or, if the annual premium earned of the form in this State is less than \$1,000,000 nationally. Successive experience periods shall be similarly determined beginning on the first day following the end of the preceding experience period.

(H) As used herein, the term "claims" means only those amounts paid, or to be paid, to satisfy policy benefits.

Severability clause

Repealer clause

Effective date

5--Modified Community Rating on Renewal option

Modified community rating option for rating of renewed policies: All individuals, regardless of their claims experience, geographical location, or occupation, shall receive the same renewal increase unless they have reached a new age plateau. If they have reached a new age plateau, then they will, in essence, receive two rate increases that year. For instance, claims losses for an insurer's individual plans require a 7% increase. All individuals on that plan would receive a 7% increase, plus, if they had reached an age increment (usually 5 years in the industry) of say their 30th birthday during the previous 12 months, they would also be given that age based incremental increase as well.

Explanation of Table 1. The dollar values in Table 1 are the actuarially determined "present value" of long term care. The numbers in the table are rounded; the actual figures fluctuate about \$1,000 between the ages of 40-60, but those fluctuations are not reflected in the table. The values in the table mean the following. If at age 41 I had \$14,300; that would be sufficient to purchase long term care insurance that would cover me the rest of my life. That purchase would take place in 10 consecutive, annual premium payments; resulting in permanent coverage for long term care. The update of values every 5 years is needed since the market will change in an unpredictable fashion. The cost of an actuarial update will be quite small. This determination which included other jobs for the actuary totaled \$450.00.

Table 1^A

Age (years)	Dollars-Cash in excess of this amount may be withdrawn tax free. The amount in this table may be invested in long term care annuities as well.
40 or younger	14,300
41-45	14,300
46-50	14,300
51-55	14,300
56-60	14,300
61-65	16,099
66-70	24,036
71-75	39,906
76 or older	68,510

^A The amounts in this table shall be updated every 5 years to determine the present value of long term care premiums currently available in Montana; and assuming fund assets earn interest at 6% per year.

EXHIBIT 24
DATE 2-14-95
HB 531

Bill Copy Page Number	Bill Copy section, paragraph, line, etc.	Comment, question, or change.
2	paragraph "2"	Lines 10 & and 11 SHOULD be changed to allow experience rating and health status on renewal--It is just that such rate changes must then be distributed as per Section 4, paragraph 6-page 7 lines 25-29. It would be easiest to strike line 10 (starting with the word "However") through line 12.
3	paragraph "1" Lines 6-8.	To avoid being interpreted as guaranteed issue, the following amendment or equivalent must be added: "If the insurer declines to issue coverage they must inform the individual declined of the Montana Comprehensive Health Association Plan".
3	Basic Plan	Benefits package is negotiable, but decent coverage for catastrophic illness is not. Also abortion must not be mandated in the Basic plan or the Association plan.
5	line 5 item (xxiii)	"other than" should be change to "or"
6	Section 4, paragraph 2.	There is the potential to confuse this to mean that after 90 days all preexisting requirements are met. The following amendment must be added: "A succeeding carrier, in applying any waiting periods in its plan shall give credit for the satisfaction or partial satisfaction under the prior plan of the time period applicable to a preexisting condition exclusion or limitation period with respect to particular services."
6	Section 4, paragraph 2	Renewability is not negotiable. The 45 days is.
7	Section 4, paragraph 3-lines 2-4.	Negotiable, but must have similar rates for similar case characteristics.
7	Section 4, paragraph 4-lines 8-15.	Not negotiable.
7	Section 4, paragraph 5-lines 16-24.	Not negotiable except that the 150% may be lower.
7	Section 4, paragraph 6-lines 25-29.	Not negotiable other than opting for the # 1 or # 5 options at the beginning of this fax.
7-8	Section 4, paragraph 7.	Not negotiable except for adding additional reporting requirements.

Bill Copy Page Number	Bill Copy section, paragraph, line, etc.	Comment, question, or change.
8	Section 4, paragraph 8- lines 17-25.	Negotiable, except that the exclusion period should at a minimum be the 3 year (non cancer) and the 5 year (cancer) we have talked about. You may eliminate the restriction on riders altogether (striking lines 17 through the phrase "due to a preexisting condition" on line 19, if that is useful--this would be the preferred position. The rational for leaving some limits on riders in the bill is purely political from my standpoint.
9	Section 5, lines 7-9.	Negotiable
9	Section 6, lines 11-19.	Negotiable
10	Section 9.	Not negotiable.
11-12	Section 10	The minimum deductible may be increased. The approved purposes listed on page 12 lines 1-4 may be changed VERY reluctantly. Otherwise not negotiable.
11-12	Section 10 probably between paragraphs 7 and 8 of page 12.	<u>THE FOLLOWING MUST BE ADDED.</u> The details may vary, but if someone provides for their long term care then the excess in the MSA must be withdrawable tax free! Here is how the proposal language reads, Table 1 is listed at the beginning of this fax. D. If the amount in the Medical Savings Account is sufficient to pay long-term care for an expected value of future costs, then the balance may be withdrawn tax free. The amounts necessary are listed in Table 1. If an individual has already paid for their long term care and if the amount in the account exceeds twice the deductible on their insurance, then they may withdraw the excess tax free. If an individual is in the process of paying for their long term care [ex: 5 years into their 10 annual payments] then any amount in excess of the funds needed to pay the remaining payments for long term care PLUS twice the deductible may be withdrawn tax free. MSA funds may be used to purchase long term care or long term care annuities as well.
17	Section 15, lines 5-13	Not negotiable except that the premium cap may be less than 150%.

Bill Copy Page Number	Bill Copy section, paragraph, line, etc.	Comment, question, or change. EXHIBIT <u>24</u> DATE <u>2-14-95</u> <u>HB 531</u>
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17	Section 15, line 10, page 17	What is the significance of the word "five" being struck? Why is the original language changed here? I think we prefer the original average as currently listed in the Association plan.
20	Section 16,	Benefits package is negotiable, but decent coverage for catastrophic illness is not. Also abortion must not be mandated in the Basic plan or the Association plan.
20	Section 16, line 14, page 20"	This should be the same as Section 3: page 4, line 26 and page 6, line-6.
21	Section 18	Not negotiable except that we should amend so that: 1-if physicians have different fee schedules for different groups then anyone may have access to each or all schedules; 2-if hospitals charge differing amounts to different groups, then those charges should be available also.

Proposed MMA amendments and our position.

Page	Section, line, etc.	Proposed amendment by MMA	We support=yes; We oppose=no.
3	Section 3, line 17 and 18	This indicates a mandatory deductible "not less than 1,000". This is inconsistent with the association plan on page 17 lines 21 and 22. The MMA would like the same provision for each plan.	Yes we would support and would like it to read however the current law does-I cannot find that in my copy of the association plan. They specify a \$1,000 deductible, but do not characterize it as either a minimum or maximum.
4	(viii), line 3	Include land or air subject to insurers utilization review	yes
5	(xxii), line 3	MMA wants to propose language to clarify "convalescent home"	yes
5	(xxiii), line 5-7	Include land or air subject to insurers utilization review	yes
5	(H)	spell out TMJ, Temporomandibular Joint Syndrome	yes
5	(C), line 27	Include land or air subject to insurers utilization review	yes
6	(j), line 8	MMA wishes to strike this line, but they may ask someone else to bring it up.	NO-we oppose.
8	lines 17-20	MMA just wants a consistent definition here and on page 3, line 4.	Don't we, all! We support a consistent definition as per earlier discussions.
9	line 2.	MMA want to strike out "an insured group health plan"	We probably agree, but I am not sure who this phrase refers to.
11	Section 10, line 16.	"a \$1,000 deductible and may deduct"---should be changed to--- "a \$1,000 deductible and may deduct <u>exclude</u> "	yes-this is more consistent language.
12 IMPORTANT	(7), line 5	"eligible medical expenses, for the"---should be changed to--- "eligible medical expenses, <u>for</u> or the"	yes

Proposed MMA amendments and our position.

Page	Section, line, etc.	Proposed amendment by MMA	We support=yes; We oppose=no.
17	Section 16, lines 21-22	This indicates a mandatory deductible "that does not exceed 1,000". This is inconsistent with the Basic plan on page 3 lines 17 and 18. The MMA would like the same provision for each plan.	Yes we would support, and would like it to read however the current law does--I cannot find that in my copy of the association plan. They specify a \$1,000 deductible, but do not characterize it as either a minimum or maximum.
18	(h), line 6	Include land or air subject to insurers utilization review	yes
19	(w), line 8	Include land or air subject to insurers utilization review	yes
19	(viii), line 20	spell out TMJ, Temporomandibular Joint Syndrome	yes
20	line 2, (iii)	Include land or air subject to insurers utilization review	yes

EXHIBIT 24
DATE 2-14-95
HB 531

To: House Select Committee on Health Care

From: Mona Jamison, Lobbyist
Montana Speech, Language, and Hearing Association
Montana Dietetic Association

RE: Proposed Amendments to HB 531

1. page 5, line 4
Following: "year;"
Delete: "and"

2. page 5, line 7
Following: "department"
Delete: "."
Insert: ";

3. page 5, line 7
Following: line 7

Insert: "(xxiv) services of a speech pathologist and audiologist covered under a case management plan of care as directed by a referring physician; and

(xxv) medically necessary medical nutrition services covered under a case management plan of care as directed by a referring physician, including assessment and counseling for the following conditions: diabetes melitus, renal disease, high risk pregnancies, malnutrition, high risk pediatrics, cardiovascular disease, cancer, gastrointestinal disease, and eating disorders."

4. page 19, line 7
Following: "year;"
Delete: "and"

5. page 19, line 9
Following: "department"
Delete: "."
Insert: ";

6. repeat amendment 3. above and number accordingly

EXHIBIT 26
DATE Feb. 14, 1995
HB 531

**Testimony by the
Montana Hospital Association
before the
House Select Committee on Health Care
HB 531**

My name is John W. Flink. I am vice president of the Montana Hospital Association. The Montana Hospital Association represents 55 hospitals and Medical Assistance Facilities. Forty-five of these also have long-term care facilities.

MHA has one major concern about HB 531: Section 18. Section 18 would require a hospital upon request to "furnish in writing the hospital's current charge for each health care service" it provides.

Hospitals recognize that consumers need to make informed choices about their health care and that they need to assume greater responsibility for the health care services they purchase. But Section 18 is not the way to promote these goals.

We applaud the sponsor for their desire to promote consumer responsibility

First, this requirement would add to hospital's costs. — *without providing any mechanism for reimbursement.*

Second, information about how much a hospital charges is usually not relevant. For seniors on Medicare, the payment rate is fixed by the federal government—regardless of what a hospital charges. SRS sets the payment schedule for Medicaid beneficiaries.

Charge information is also not relevant for patients covered under a managed care plan, because their plan usually negotiates the price with providers.

In addition, the total cost of receiving medical treatment is affected by several intangibles. For example, a hospital's "room rate" is usually only a small part of the cost for obtaining medical treatment in a hospital. Severity of the illness, a physician's practice patterns, other medical conditions, and the intensity of treatment all affect overall cost.

EXHIBIT 21 page 2 of 2
DATE Feb. 14, 1995
HB 531

For these reasons, we urge the committee to reject
HB 531.

HOUSE BILL 466

Mr. Chairman, Members of the Committee:

My name is Greg Van Horssen. I represent State Farm Insurance Companies in Montana.

State Farm supports Representative Nelson's House Bill 466 with some amendments that I will be discussing.

State Farm is a mutual company which means that it is a company owned by its policyholders. As such, State Farm's primary responsibility is to its policyholders and I am hopeful that the proposed amendments will address those interests.

State Farm has testified before this committee on previous occasions regarding health issues. As I have previously stated, relative to some of the other proponents to this bill, State Farm is a small player in the group health market.

State Farm offers both group health and individual health products to Montanans, primarily as an accommodation.

Nonetheless, as the small employer health insurance program has developed, State Farm has become concerned about potential shortfalls in the program and the funding source for those shortfalls.

Under the current small employer program, any shortfalls are made up by all carriers of health insurance in Montana, even those insurers who do not participate in the small employer health insurance program.

These amendments do two things, first they amend Section 33-22-1819, MCA by requiring that the program be reviewed annually to ensure that the program is actuarially sound. In other words,

the program must be reviewed to make sure that the premiums are adequate to cover projected losses.

The second amendment simply provides that, for individual carriers who are assessed to make up shortfalls, those carriers are assured a cap of 5% of their profits.

State Farm believes that these amendments will strengthen the health insurance market in Montana by allowing a health insurer the ability to forecast potential exposure for any shortfalls in the small employer health program. With these amendments, State Farm supports Representative Nelson's House Bill 466.

Thank you.

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Select Comm. on Health Care COMMITTEEBILL NO. HB 531DATE 2/14/5 SPONSOR(S) Rep. Orr

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
<i>John H. Johnson</i> 68 Wilson Ave G. C.	<i>Self</i>	531		X
<i>Gon farrut</i>	<i>Self</i>	531		X
<i>Mona Jameson</i>	<i>Mt. Dietetic & Soc. Mt. Speech, Lang. + Hearing Ass'n.</i>	531	✓	
<i>Richard D. Tappe</i>	<i>MT Right To Life Ass'n</i>	531		X
<i>Raymond Cowen</i>	<i>Self</i>	531		✓
<i>John Flink</i>	<i>MT Hospital Ass'n.</i>	531	✓	
<i>LARRY AKEY</i>	<i>MT ASSOC OF LIFE UNDERWRITERS INDEP INSURANCE AGENTS OF MT</i>	531	✓	
<i>Mary McGee</i>	<i>Mt Clinical Mental Health Counseling Ass'n.</i>	531	✓	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS
ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Select Comm. on Health Care

COMMITTEE

BILL NO. HB 531

DATE 2/14/95

SPONSOR(S) Rep. Orr

Rep. Nelson (HB 466)

Rep. Arnett (HB 533)

Rep. Carey (HB 548)

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NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
JOHN VANDENBURG	SELF	531		X
Dean Randal	NADA Auto Part	531		X
Dean Randal	✓ - -	466	X	
Dean Randal	- - -	533		X
Tanya Ask	Blue Cross & Blue Shield	531	X	
David Harmon	Mental Health Assoc.	531	X	
LARRY ALLEY	MT ASSOC OF LIFE UNDERWRITERS	531	✓	
Paul Gorsuch	Project HEAR	531		✓
REWYNIA	SELF	531		X
JANET ROBIDEAU	MFA/MCLA	548 531		X
Mike Swartz	Billings Anesthesiology	531		X
Kate Cholewa	MT Women's Lobby	531	X	
TOM BILODEAU	MEA	531	X	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

Arlette Randal

Eagle Forum

X

Laurie Koutnik

CC of mt

X

Tom Haggood

HIAA

531 X

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Subject Sen. Health Committee BILL NO. H 3531
 DATE 2/14/95 SPONSOR(S) Rep Orr

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
John Mendenhall Great Falls	Self	531		X
Leanna Garcia Great Falls	self	531		X
James Bull Great Falls	self	531		X
Ron Weiman Great Falls	Self	531		X
PAUL B. COMER GREAT FALLS	SELF	531		X
KATHY McGowan	McMHC	531	X	
James Dingshaugmo Great Falls	self	531		X
Raymond Fowler M.D.	Self	531		X
Jerome L. Coe	mt mt 531	531		
Ed GRIFFIN	MT 531	531		
David D. Gorman	mt chambers			X
WM. PETER HORST	Self	531		X
Robert L. Hunter Billings	self	531		X

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS
 ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

Susan York
Don Allen

Heal Mt
UMBP

support
Support

MINUTES

MONTANA SENATE
54th LEGISLATURE - REGULAR SESSION

JOINT SELECT COMMITTEE ON HEALTH CARE

Call to Order: By CHAIRMAN STEVE BENEDICT, on March 7, 1995, at
5:35 p.m.

ROLL CALL

Members Present:

Sen. Steve Benedict, Chairman (R)
Rep. Scott J. Orr, Vice Chairman (R)
Sen. Dorothy Eck (D)
Sen. Mike Foster (R)
Rep. Duane Grimes (R)
Sen. Judy H. Jacobson (D)
Sen. Ken Miller (R)
Rep. Bruce T. Simon (R)
Rep. Carolyn M. Squires (D)
Rep. Carley Tuss (D)

Members Excused: None

Members Absent: None

Staff Present: Susan Fox, Legislative Council
David Niss, Legislative Council
Jennifer Gaasch, Committee Secretary

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: This was concerning the following bills:
HB 511, HB 542, SJR 14, HB 405, SB 405,
HB 531 and HB 560.

Executive Action: None

{Tape: 1; Side: A.}

The nature of the meeting was to have public input on all of the
bills mentioned above and then questions would be asked by the
committee members. Executive Action would be taken at a later
date.

Discussion:

CHAIRMAN BENEDICT said he would like to know how the members of
the committee would like to handle proxies.

SENATOR MIKE FOSTER said due to the circumstances that they could use written proxies for the votes in committee.

CHAIRMAN BENEDICT replied he would not have any problem with that. If they worked with blanket written proxies that would be fine.

Motion:

SEN. FOSTER MOVED to allow the use of written proxies to cast their votes.

Vote:

The MOTION CARRIED UNANIMOUSLY.

Discussion:

CHAIRMAN BENEDICT said the sponsors were notified about their bills and they were told they would not be required to open and close on their bill. He said they would take testimony from the public on different groups of bills and then after everyone has had a chance to testify, the committee members would ask questions.

Public Testimony:

SENATOR EVE FRANKLIN, SD 21, said she hoped they could put together a good package that would create some change.

Arlette Randash said SB 194 would not be considered by the committee, but it needs equal consideration and scrutiny just as HB 511 does. If the committee is going to investigate new directions of health care, SB 194 should be given consideration because it calls for the diminishing of the Montana Health Care Authority as created by SB 285. Its sponsor realized socialized medicine results. She said a decision would not be complete if SB 194 and HB 511 were not on the table.

Jack Molloy, a member of the Health Care Authority, said he would like to address the issues of the Health Care Authority as in SB 405. He said as far as the Montana Health Care Authority has been a wonderful exercise in listening to the people of Montana and has done a good job of being objective. He said they are at the cross roads and nationally there is a void which is being filled by cooperative efforts. He said it is too early in the process to back the stake out of an authority position in determining the health care services, needs and systems it supplies to its citizens. He said the Health Care Authority realized that they lack Montana specific data. They are not funding things in a matter that will give them legitimate data. He said it was important that the legislature send a message to the vulnerable populations of Montana that they do matter. He said voluntary purchasing pools would enlarge the base of health

insurance which would make it more available and more affordable. He said SB 405 does a good job of organizing the needs of voluntary purchasing pools. They feel the medical savings accounts are one way to encourage people to become insured. He said they need to have a way to measure the affects of those things. He said for that reason it is necessary for a Health Care Authority body that is fully funded by the state who is going to hold the industry to its obligations to the people of Montana if necessary. He said it was not a way for the state to take over health care. He said the only objective party that should oversee that should be the state.

Laurie Ekanger, representing the Governor's office, she said the Governor did support continuation of the Health Care Authority. It is in the budget to continue it and primarily to continue the collection of the data base. She said urged them to continue the data base function. **Laurie Ekanger** said the Governor's office supports the concept of Purchasing Pools. They think HB 405 looks like a good approach. There may be some need to protect those people who pay into a Purchasing pool. Concerning Medical Savings Accounts they felt HB 560 was the cleanest approach to start out.

Ed Grogan, representing the Montana Medical Benefit Plan, Montana Medical Benefit Trust and the Montana Business and Health Alliance, stated the Montana Health Care Authority knows the business and it gave government control of the health care. He said they did not want to see any more government control and therefore supports **REPRESENTATIVE JOHNSON'S** bill which is HB 511. On the Voluntary Purchasing Pools he favors HB 405 and disagrees with SB 405. He said SB 405 was adding more government control. He said that was too high a number for a small group. Concerning Medical Savings accounts, they support HB 531 and are against HB 560. Perhaps there could be a compromise of the 2 bills. They like the \$3,000 limit in HB 560. He suggested all of the premium dollars to all be paid with Montana tax free dollars and then go over and above that to \$500 a year per person or more to be put in the medical savings accounts. He said they looked at Medical Savings Accounts as a cost saving device being able to bind a persons insurance and pay the deductibles and co-payments with free tax dollars.

Tom Hopgood, representing the Health Insurance Association of America (HIAA), said concerning Medical Savings Accounts they have no opposition to the bills that had been introduced or to the concept of the Medical Savings Accounts. He said that was not a cure of all of the problems, but it is an alternative to take advantage of. Concerning Purchasing Pools one of the things that has to be addressed in order for health care to be reformed is cost. He said health insurance reform is not necessarily health care reform. They have to address the cost of health care. The Purchasing Pool concept is a cost containment measure. They have endorsed both HB 405 and SB 405. The HIAA believes they should infuse into the Purchasing Pool statute a great deal of

flexibility to allow innovation into the market place and allow cost cutting. They would lean more toward HB 405.

Larry Akey, representing the Montana Association of Life Underwriters, he said they represented around 700 professional insurance agencies. He said there needs to be some official body that would continue to look at health care in Montana. He said concerning Purchasing Pools they believe they will serve to contain costs in the market place. They need to look at both HB 405, and SB 405 and recognize that they were having licensed insurance agents selling licensed insurance products through a different marketing mechanism. He said they question if there needs to be further layers of regulation and whether those layers of regulation will in fact serve to reduce the cost controlling capabilities of the Purchasing Pools. They think the mechanism in HB 405 probably has a greater chance of success in the market place. If they believe there needs to be further regulation in the market place, please remember they are talking about licensed insurance agents selling licensed insurance products. Concerning Medical Savings Accounts, they think they are a concept worth exploring. They could not believe they will cure all of the problems that exist in the state. They think HB 560 does have a few modest advantages over HB 531. HB 560 also has some problems that HB 531 does not. Medical Savings Accounts are to allow individuals to buy health insurance with free tax dollars. It could be more adequately accomplished by making health insurance premiums fully deductible. He said there are at least 3 bills going through the system that do that. He urged the committee to endorse both Purchasing Pools and Medical Savings Accounts.

Susan Good, representing Heal Montana, said concerning the Montana Health Care Authority, SJR 14 was a creative and practical solution to that. She said concerning Purchasing Pools they are in support of HB 405. Whether a person chooses the threshold of a Purchasing Pool to be 1,000 or 750 or 862 does not really matter when they get to the point of when they have the group assembled the group drops below whatever number has been selected, at which point does the group cease to be a pool? She suggested there should be a formula developed to spell that out because it had never been addressed. Concerning Medical Savings Accounts, the concept is the centerpiece of the Heal Montana project. She said when an individual uses their own money for health care they are going to be more careful in the way they spend that money. HB 531 and HB 560 should somehow be combined in a way that the best concepts of both are employed. She said they would help come up with solutions to the problems that face all Montanans.

Tanya Ask, representing Blue Cross Blue Shield of Montana, she said they feel they feel the Health Care Authority process has been a very valuable process for the State of Montana. She urged that should be continued. Voluntary Purchasing Pools are a good concept to health with affordability of health care. It is part of the answer. They like HB 405 and can work with SB 405. They

urge an open process and feel that HB 405 will give that a more open process. She said she would like to address the 1,000, there is not a number that they can point to and say that will do it. She said 1,000 was put in there because they wanted to have a large enough number so there can be some attrition and still have a viable mechanism. That number is 1,000 eligible employees, not 1,000 people. She said the numbers would remain relatively constant. She said they urge them to consider a large enough number. Medical Savings Accounts do have a place in the health care reform equation. It does encourage individual responsibility. They have raised some questions in the drafting of HB 560. They will work on those problems. She passed out testimony for 2 days. (EXHIBIT #1 and #2)

Dean Randash, representing NAPA Auto Parts, read his written testimony. (EXHIBIT #3)

Bob Turner, representing the Department of Revenue, said he would like to address Medical Savings Accounts. He said the effective date on the bills should apply retroactively. They should also make sure that there are no double benefits. He said if they decide that a person can withdraw a certain amount out of the Medical Savings Account and put it into an IRA, that is another benefit and a double benefit. He said if during the time that money is in the Medical Savings Account and it is taken as an exclusion by the taxpayer and is put into a mutual savings account, what happens if the taxpayer takes a loss? Does the taxpayer get to use that loss, or is that lost because it was already taken as an exclusion? He said it would be a lot easier to administer if there was a maximum amount of contributions that could be made as an exclusion on the tax return.

CHAIRMAN BENEDICT replied he would like the Department to come to the committee with possible amendments or things they need to fix in the bill.

Bob Turner replied they would do that.

John Flink, representing the Montana Hospital Association, read his written testimony. (EXHIBIT #4)

{Tape: 1; Side: B.}

Claudia Clifford, representing the State Auditor's Office, the Commissioner of Insurance, and the Commissioner of Securities Office, said the commissioner served on the Health Care Authority and said that although insurance reform is needed, insurance reform is not comprehensive health care reform. There is a need for a good data base of information in order for the legislature to address other aspects of insurance reform, they support any legislation with adequate work on a data base. She read her

written testimony which included proposed amendments.

(EXHIBIT #5) She stated they had talked with REP. SIMON about the amendments and he had agreed with them.

Frank Cote, the Deputy Insurance Commissioner, said that Purchasing Pools could be beneficial in the market place. Both of the bills could help consumers get affordable health care insurance. HB 405 has very little regulation in it. SB 405 has some more regulation. The committee must decide how much regulation would be needed. He said the committee should require the registration of the Purchasing Pools. He said the Purchasing Pools manager should have some fiduciary responsibility so the consumers would be protected. He submitted (EXHIBIT #6).

Tom Ebzery, representing Yellowstone Community Health Plan, said they supported the Health Care Authority a few years ago, but a few weeks ago he supported the Health Care Advisory Council and had some suggestions on how that might be composed. He said on page 1 of the bill, they had talked about listing a lot of things to do. He said he had a problem with going out and bringing in people from all over the state. He recommended that there be a legislative committee as the advisory committee. He said HB 511 should go forward and the work that has been done, the certificate of public advantage over in the Department of Justice should continue. He said they were an HMO and every time they see a bill that comes up on small group or HB 531 those are plans set up for indemnity plans. HMO's are based upon co-payments and they would like to give them input in terms of schedules. He asked that they will keep managed care and HMO's in mind because they just do not fit under the circumstances.

Riley Johnson, representing the National Federation of Independent Businesses, said they agreed with Tanya Ask on the procedures in the past on the Montana Health Care Authority. He said they supported HB 511 and that it is time they take that experience and make it voluntary. He said they agreed with Riley Johnson in that the composition be looked at. They feel they are confident in the legislators. They would like the composition looked at and changed to a primary legislative committee. The problem they had about the data base was the detailing of what it would be used for and what it really would mean. He said regarding Voluntary Purchasing Pools, primarily HB 405 addresses the issue. He said it has a few things to work out and they would help in that effort. He said Voluntary Purchasing Pools give them cost reduction. He said on Medical Savings Accounts, they think that is affordability and responsibility. He said they support HB 560. They would like to see HB 511 to eliminate the Montana Health Care Authority, HB 405 for Voluntary Purchasing Pools, and HB 560 for Medical Savings Accounts.

David Owen, representing the Montana Chamber of Commerce, said the Chamber supported the creation of the Montana Health Care Authority. He said he does not have a specific suggestion on what form that authority would take in the future. He said concerning Purchasing Pools they were going to be important and he encouraged them to be voluntary, etc. He said they believe in that concept.

Keith Kovash, representing the Montana Association of Health Care Purchasers, read his written testimony. (EXHIBIT #7)

Anita Bennett, representing the Montana Logging Association, said they have found that the Health Care Authority did bring forth a lot of information. They have concerns of the process of bringing forward that information. She said they never discussed what the cost was to the consumer and to the employer, and the bottom line as to access of services. Guaranteed issue and affordability are not compatible. She said in regards to Voluntary Purchasing Pools, HB 405 seems to be more conducive to a better competitive arena and arrangement. They are a fully insured health insurance program. In regards to Medical Savings Accounts, they see that as an important step in regards to the timber industry people. She said those accounts would assist them in having accessibility of their own dollars put into the medical arena as they are needing the services at that point in time.

SENATOR JUDY JACOBSON, SD 18, Butte, said there was a lot more regulation in SB 405 and they could work some of that out together. She said SB 405 does allow individuals to participate. She said with small group, there would not be a guaranteed issue if those people were not eligible for small group. They could participate in a Purchasing Pool. The Purchasing Pool could certainly disallow them. One of the biggest problems is they have self-employed and young people in the state who cannot participate in any plan at all. She said SB 405 would not allow groups or individuals to be excluded based on their occupation. That is not included in HB 405. She passed out a summary sheet. (EXHIBIT #8)

REPRESENTATIVE GRIMES asked Larry Akey what were the downside to and the upside of individuals included in these bills regarding Purchasing Pools? Larry Akey said that there were both upsides and downsides to including individuals in a Purchasing Pool. There is a fundamental difference between individuals purchasing insurance and small employers purchasing insurance. There is a different motivation. Individuals are usually purchasing insurance because of an anticipated health risk. They are motivated by their health concerns. Employers are generally motivated by a concern in the labor market. They want to attract the best quality of employees they can. If they start putting individuals into pools they have strong potential for adverse selection. He said initially they ought to look at Purchasing

Pools fully for employers so they do not have that potential for adverse selection. That would drive the cost up. **REP. GRIMES** said **Mr. Akey** expressed some concerns about HB 560. He asked **Mr. Akey** to explain those concerns. **Mr. Akey** said HB 560 was more tightly crafted than the Medical Savings Account portion of HB 531. Under HB 531 an account administrator was defined as an employer. Under HB 560 an account administrator may be an employer who has a self-insured plan. Under HB 531 they have said a self employed individual was an employee. Does that also made that self-employed individual an employer, if it does, then there would be a self-employed individual acting potentially as his or her own account administrator. He said the definition of dependent in HB 560 is more in line with the kinds of definitions they use in the insurance industry. The definition of a dependent in HB 531 is a definition that looks like the tax code. He said they were talking about a health-related product and so it would make sense to them to have dependent defined in the Medical Savings Account bill more in line with the health care product that in the line of the tax code. HB 560 speaks to a specified dollar amount that could be contributed to a Medical Savings Account. It is important to recognize if they want to have deductible insurance premiums they may want to address that in a separate issue than Medical Savings Accounts. HB 531 has a nebulous amount that could be contributed to a Medical Savings Account based on premiums plus deductibles plus the co-payments they would have for a \$1,000 deductible health insurance policy. There is nothing in the bill that says there is a specified dollar amount that could be contributed to the Medical Savings Account.

REPRESENTATIVE SIMON said there were a lot of amendments that were drafted. He asked how they might proceed to make the amendments available to the interested people. **CHAIRMAN BENEDICT** said they could distribute them tonight. **REP. SIMON** asked **Larry Akey** if **REPRESENTATIVE NELSON'S** bill, for example, or **SENATOR DOHERTY'S** bill that deals with deductibility of health insurance premiums passes and they pass a Medical Savings Account bill also, would a person then not be able to deduct the premiums that they pay and make a contribution to a Medical Savings Account. **Larry Akey** replied that if that were to happen, that a \$3,000 cap on Medical Savings Account, would be more sufficient to help pay for the deductible and the co-payments of a policy for which they would have already been able to deduct the premiums. **REP. SIMON** asked **Bob Turner** if Medical Savings Accounts have been referred to as a Medical IRA, and under an IRA arrangement if that was applied to gains or losses based on interest on a regular IRA, how would that be treated as far as the Montana tax codes? **Bob Turner** replied the way it is treated is they put money into a regular IRA and it is put in a mutual fund and it loses money, they do not take a loss at all. They report that when they pull the IRA out. They already took the loss when they took the exclusion when arriving at the net gross income. **REP. SIMON** asked if a Medical Savings Account would be handled differently. **Bob Turner** replied no it would not. He said there is an

amendment put forth by the Department of Revenue so that if they did have a Medical Savings Account and they took out money from that to pay health insurance premiums, that would have to be deducted as an itemized deduction.

REPRESENTATIVE TUSS said in **Dr. Molloy's** testimony that he saw great value in collection of data and the utilization of that data. She asked him to give some definition and parameters to that data base and further explanation of how he would see that utilized. **Dr. Molloy** said the issue of the data base was to be one of the next projects of the Health Care Authority. He said there was the component of cost, who was paying for health care in Montana and how much money was being collected from state and federal agencies and where that money was going. From the stand point of providers, they wanted specific data on the cost of care for specific illnesses that they could compare across the state. One set of data is more complex and used to evaluate the health care system and from that data they distill specific data that they would be able to consume as usable and would make it very easy for consumers to compare that data. That has to include the payers of health care, who they are covering, what kind of dollars, and what benefits. He said people who testified said they want more consumer and more personal responsibility for how they spend their health care dollars, but that is very hard to do when there is data missing. The only data that is available is that data the providers or the insurance companies want the consumer to know about. He said they envision a data system to evaluate how the system works and how it is paid for and a system that is compatible for individual use to make their own health care decisions. **REP. TUSS** said it was time for the Health Care Authority to take a deep breath, look backward, and look forward. She said some references need to perhaps reflect the health council as opposed to the health authority. The Health Care Authority now has historical and institutional history throughout the state. How would he envision a transition between the authority and the council considering the data base? **Dr. Molloy** said the past year and a half has been consumed by the mandate of the previous legislation. Early on they realized the data that was available was at best several years old and a lot of it was extrapolated to Montana. It took a lot of time, effort, and expense to get usable data to present the 2 health care plans. He said they would have wished they could have moved forward in the last biennium to develop the data base system. He said those on the authority are uneasy about how raw data can be collected and disseminated and perhaps misused or misrepresented. They feel it is very critical that the knowledge be transported to and utilized in whatever the Health Care Authority or the Health Care Advisory Council or whatever it becomes. That knowledge has to be made available and those people would have to familiarize themselves with that in order to understand what data was necessary.

SENATOR ECK said **John Flink** suggested that the committee combine HB 542 into the advisory council. **John Flink** replied he made that suggestion because when he talked to **REPRESENTATIVE TASH** he was concerned with implementation. They felt there might be some way to meld them. He said the goals to improving the public health system in the state are a part of what they want to pursue and maybe the advisory council would be the ones to do that instead of establishing a separate entity out there. **SEN. ECK** said she would like to know which group it is, is it the Montana Public Health Association that worked on that proposal? **REP. TUSS** replied it was the Department of Health and Environmental Sciences.

Mike Craig, representing the Montana Health Care Authority, said the Montana Public Health Task Force was affiliated with the Department of Health and local public health agencies, and their interested parties got that proposal together and brought it forth to the authority. They agree that they do not want to see any duplication, but must be reminded that there is a statutory link between the Department of Health and the local public health agencies. If that is combined with HB 511 there may be some legislation problems. The task force that is created by HB 542 could be dealt with through the new council. Department of Health would still have to be a main player. **SEN. ECK** said she did not understand what the rationale was for putting it into SRS. **Mike Craig** replied the rationale was because of the appearance that HB 511 would be what the majority of the legislature wishes it to happen, that SRS will take the responsibility of supporting the council. They suggested that they strongly encourage the work of data collection to go along with that somehow so that it does not get lost. HB 511 wipes out the Health Care Authority in its entirety including data base.

REP. SIMON stated that one of the reasons it was chosen to be put over there is because SRS is already involved in a lot of data collection.

SEN. JACOBSON replied that there are data base systems. Western States has instituted a data base. They already have one.

JOINT SENATE-HOUSE SELECT COMMITTEE ON HEALTH CARE

ROLL CALL

DATE 3-7-95

[illegible]



Blue Cross BlueShield of Montana

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EXHIBIT 2
DATE 3-7-95
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Charles Butler, Jr.
Vice President
Government and Public Relations

March 2, 1995

Senator Steve Benedict
Chair, Joint Select House-Senate
Health Care Committee
State Capitol
Helena, MT 59620

RE: HB 531

Dear Mr. Chairman:

House Bill 531, introduced by Representative Scott Orr, was heard by the Health Select Committee before transmittal. This proposal represents the HEAL Montana approach to health care reform.

At the hearing, we raised a number of concerns with this approach. As chair of the new joint House-Senate Health Care Committee that will consider legislation and issues contained in it, we wanted to share our concerns with you. The concerns are in three parts: Definition of a uniform health benefit plan and insurance market reforms, general concerns, and data disclosure considerations.

Uniform Health Plan and Insurance Market Reforms

There are numerous problems with Sections 2-4 as written. New Sections 2-6 apply to both group and individual insurance. Many large and not-so-large employer groups self-insure and are therefore not subject to these requirements. If more burdens and regulations are added, more employers will opt out of the regulated market to self-insurance.

- a. The outline for the basic or uniform benefit plan should address issues, not attempt to legislate contract language. Actual language appears to be dictated in this legislation.
- b. The Basic or Uniform Benefit Plan on page 3 contains 80/20 coverage; this is not basic, but actually pretty rich. If the attempt is to get more individuals covered by providing a lower cost alternative, a scaled-back approach should be explored.
- c. Covered expenses use a usual, customary, and reasonable (UCR) reimbursement system--what about other payment systems:

- Managed care

- Capitation - fixed payment - amount
 - Diagnostic Related Groups (DRGs)
 - Resource-Based Relative Value System (RBRVS)--professional services reimbursement methodology
- d. Benefits are scheduled for transplants--what if costs change or new transplants become norm? Benefit levels should not be scheduled in statute.
- e. Disability insurance covers illness/accidents. Coverage for mental illness does not include mental retardation, which is a condition, not an illness that improves with treatment.
- f. Specifically excluded medical expenses or services are listed. Again, why not allow traditional contract exclusions to apply? As an example, exclusion (G) is for complications to a newborn, unless no other source of coverage is available. If this is the basic plan that will be offered, it should cover newborns just as all other insurance in state must under regular insurance law.
- g. Section 4 (2) requires only a three-month waiting period before full coverage is available, not the standard 12 months allowed elsewhere in insurance law.
- h. Section 4, Lines 26 and 27 give individuals who don't pay their premiums 45 days of free coverage . . . We all know nothing is free, and the rest of us will pay.
- i. Subsection 4 appears to allow an employee to elect to stay on his or her former employer's group plan even after going to a new place of employment with its own benefit plan. Conversion contracts, even at higher rates, don't pay the full cost of coverage. Capping the premium will mean small businesses and individuals pick up the tab.
- j. A conversion cap of 150 percent of premium charged by the five insurers who write most individual policies is mandated, but these contracts may provide extremely different individual benefit levels.
- k. Section 8 deals with preexisting look-back period of only 24 months. This only applies to Yellowstone Community Health Plan and Blue Cross and Blue Shield of Montana, not to the rest of the marketplace as written.

Senator Steve Benedict
Page 3
March 2, 1995

General Concerns

- a. We're not sure what New Section 5 on page 9 does. This section is entitled "Commissioner Not to Prohibit Premiums Based on Loss Ratio Guarantee."
- b. There is a problem with standardized claim form mentioned. This does not allow the traditional hospital form, the UB 92, to be used or accepted, nor is the standard dental form recognized. Also, what about including Workers' Compensation and Medicaid in standardization to further streamline administration?
- c. Health benefits are being expanded for the MCHA--sick pool--a subsidized, state-sponsored pool. When designed, it was never intended to be low cost but was designed to be the pool of last resort. Subsidized by the insured market--individuals and small employers. Please note that many large employers such as government entities and hospitals self-insure--they are not part of assessment.

Data Considerations

Considerable sensitive cost and pricing information is to be made available to any person, not just those shopping for services. What is now illegal under antitrust laws would be legal, the banding together of providers to compare, and potentially set, prices. The temptation is for providers to discover that their prices are lower than their peers and to raise them.

Subsections 2 and 3 address health care providers and hospitals. Each are given 30 days to respond to requests for current charge information. If an individual is shopping for a health service, 30 days is usually too long to wait for the information. There is nothing about past charge experience for a given service, or the history of bundling or unbundling charges, which can lead to a significant distortion in the cost of a service.

Subsection 4 requires about twice the information from insurers. Some of the general marketing information is already available because of marketplace demands, but serious problems exist with sharing proprietary pricing information with our competition. In fact, a recent Supreme Court case to which Blue Cross and Blue Shield of Montana was a party dealt with a demand for and protection of that sort of proprietary information.

Information such as this has a great deal of value to the developer of the information. This is probably a state appropriation of private property without compensation.

There is also a significant difference in fines between insurers and all other data providers who fail to provide information as required. Insurers are fined \$1,000 for each failure to

Senator Steve Benedict

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March 2, 1995

provide information and providers are fined \$500.

I urge your serious consideration of these concerns as these reform proposals move through the process.

Sincerely,

A handwritten signature in cursive script, appearing to read "Chuck", written in dark ink.

Charles Butler, Jr.
(406) 444-8263

201CB301.1K/jmm

cc: Representative Scott Orr, Committee Vice Chairman
House Speaker John Mercer
Members of the Committee
Susan Good
Peter Blouke

Exhibit # 3

EXHIBIT 3
DATE 3-7-95
1

Combined Select Health Committee
March 7, 1995
Dean M. Randash - NAPA Auto Parts

Subject: MSA accounts

I would like to share my experience concerning my own creation of "MSA" accounts that took place before I even knew or understood what MSA accounts were.

In 1989 I was approached by Blue Cross Blue Shield to let them our group health insurance. We had an employee meeting to discuss the features and benefits of the deductible plan that we were currently on and the HMO plan the agent was selling. During the meeting the number one complaint of each employee was that they were not able to come up with the deductible when it was needed. The agent capitalized on that fact and really worked the sale concerning the small co-pay amounts.

The employees decided that they wanted this HMO Blue Cross Blue Shield program. Over the next three years the premiums increase over 75%. To compensate I was forced to charge 25% of the employee premium back to the employee. In March of 1994 I had enough, knowing the insurance company was playing pricing games, because we had no major medical claims, I went health insurance shopping. All employees agreed on the John Alden insurance even though they were not the cheapest. The new group premium was 42% lower than Blue Cross Blue Shield, in fact it brought our premiums down to the same level that we had been paying three years earlier.

I still needed to address the problem of the \$250.00 deductible. What I did was to take the dollars we saved in the premium reduction and placed it in a separate account receivable account for tracking purposes. At any time during the year the employee can submit a copy of a medical bill and we will write a check up to the deductible amount. Since it is their money it is necessary to return what ever amount is left in the account to them at the end of the premium year.

I can see from talking with them and in my own experience that this has done two things. One is made it possible for them to meet the deductible with out fear of where the money is going to come from. The other thing is it has made them, along with myself, far better managers of our health care spending since it was our money being spent.

As an new advocate of this concept, HB-531 seems to me to better addresses the amount of dollars eligible to be placed in the MSAs. HB-531 also seems to have better flexibility toward the total medical and insurance expenditures inclusion toward the total dollars per a given year.. HB-560 with a fixed amount could be a real problem for larger families. One thing that I didn't see in either plan is the treatment of a married couple filing jointly being treated fairly and equably in comparison to filing separately.

if they trace her date of pregnancy back to a week before her policy went into effect she is an ordinarily prudent person with a pre-existing condition who would have still sought medical advice for that condition. They would like to see pregnancy not treated differently.

Tom Hopgood, representing the Health Insurance Association of America, said he would like to address HB 446 and had amendments they would like to offer to that bill. (EXHIBIT #1) He said the amendments were mostly technical. On line 5, page 3, they think that would be a good idea to strike that so they do not write a pre-existing condition on pregnancy. He said the bill sets a pre-existing condition for a health benefit plan, look back for 3 years, exclude it, then for a period of 12 months. It is a little better than it is for other types of disability policies which are on the market. He said he had some amendments to propose. (EXHIBIT #2) He said this bill said once a pre-existing condition is covered under a health insurance policy they, can transfer their health insurance policy to another company and they would not have to satisfy the pre-existing condition again. There is a provision in HB 533, Section 3, page 2, which would address the spread of premium increases. When a person becomes ill some health insurance companies have taken that person's premiums and increased them because of adverse claims experience. In Section 3, the only thing that should increase an individual's policy is an increase in his/her age. Any other reasons to increase that policy have to spread across the entire market. The company cannot take revenge on a person for getting sick. The way the bill was originally written it would apply to group policies. The thought was that group policies were already sufficiently covered under the small group act. He said the amendments would take care of that. He said they had one amendment prepared for HB 531. (EXHIBIT #3) He said that amendment was on page 7, line 30, and has to do with the disclosure requirements. Health care insurers and producers are to provide, at the point of application, a set of materials continuing on page 8. They think that is a lot of material. What it appears they really want is a general history of what is going on with the premiums to particular policies. They feel by the company providing a general narrative of what has gone on with the companies premiums over the past 5 years would be sufficient for that. He said they were still discussing things between the interested parties.

Claudia Clifford, representing the State Auditor's Office and the Commissioner of Insurance's Office, said was going to address HB 446, HB 533, and SB 322. The goal is to address portability. They key to understanding portability is whether or not they can even get their next policy. She that is what the issue of guaranteed issue is about. These bills deal with pre-existing conditions. She said in current law, a pre-existing condition is a problem that has occurred, there is a medical diagnosis, it is something that is documented. In one of the bills they add a definition of what pre-existing means. It would be what any



MONTANA HOSPITAL ASSOCIATION

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EXHIBIT 4
DATE 3-7-95

Testimony by the
Montana Hospital Association
before the
Joint Select Committee on Health Care Issues
March 7, 1995

The Future of the Health Care Authority

My name is John Flink and I am vice president of the Montana Hospital Association. MHA represents 55 hospitals and Medical Assistance Facilities. In addition to providing acute care services, 45 of these facilities also provide long-term care services.

Two years ago, the Legislature recognized that serious problems afflict our state's health care system, and—with the enactment of SB 285 and the creation of the Health Care Authority—began the process of fixing these problems.

MHA strongly supported SB 285, and we have strongly supported the work of the Authority over the past 18 months. And we believe it is critical that the Legislature build on the Authority's work in the upcoming biennium.

As we look ahead to the next two years, we want to call your attention to several policies and issues that we believe must be addressed:

- **The problems that led to enactment of SB 285 have not gone away.** In fact, they are getting worse. Continued reductions in Medicare and Medicaid reimbursement have forced hospitals and other providers to shift even more of their costs to privately-insured patients, thus forcing increases in health insurance premiums for working families. Massive reductions in the Medicare and Medicaid program—as envisioned by some in Congress—would accelerate this cost-shifting. Meanwhile, the numbers of uninsured and underinsured Montanans continue to grow.
- The changes now occurring in the health care delivery system—the movement toward coordinated and managed care—will accelerate in the next biennium. These changes could result in savings to both privately- and publicly-insured persons. But to realize these savings, we must take a new look at the health care regulatory environment, removing barriers to coordinated care.
- We must continue to work toward achieving two principles: (1) **increasing the number of Montanans who have health insurance coverage** and (2) **reducing the cost of that coverage.**
- The Achilles heel of our efforts to address access to health care services and their cost is **data**. We certainly can't design and implement a comprehensive data system in the next biennium, but we can begin to make some decisions about what data is needed, how it should be collected and how it should be used. We also need to look at what information consumers need to make more informed decisions.
- Regardless of what form it takes, **there should be a clearinghouse for health care**

policy questions. We don't care whether you call it the Health Care Authority, the Health Care Advisory Council, or the office of health policy within the new Social Services super agency—but somewhere in state government there should be a clearinghouse for the discussion of health care policy options.

MHA supported HB 511, sponsored by Rep. Royal Johnson, because, in our view, it is the only realistic vehicle for addressing the problems facing the health care system.

However, we would suggest that you consider several modifications to this measure:

- We would urge you to expand the purpose on page 1, lines 24 to 28 to include monitoring development of systems for providing coordinated care and their impact on the overall cost of health care services.
- Strike Sections 17 through 21 in HB 531—the sections relating to data—introduced by Rep. Orr. As amended in the House Select Committee, HB 511 would require SRS to make recommendations to the Legislature for a comprehensive data system. We feel this is the most responsible way to approach the data issue.
- Incorporate the tasks mandated by HB 542, sponsored by Rep. Tash. Improving the public health programs in the state certainly is consistent with the goals of increasing access and reducing cost. Incorporating Rep. Tash's bill would enable us to pursue those goals, without establishing yet another task force.
- In its report to the governor and the Legislature, the Health Care Advisory Council should be required to recommend legislation for consideration during the 1997 session that would address the twin goals of health care reform: (1) to expand access to health care services and (2) to reduce the growth of health care costs. This report should also include administrative recommendations that would help achieve these goals.

Finally, I want to say that we have mixed feelings about Rep. Johnson's bill. While we see it as the bill with the best chance of passing, we also recognize that it has weaknesses.

For example, without additional staff resources, the Health Care Advisory Council will certainly be limited in the scope of issues it can address. And, while that may be politically popular in this legislative session, it does not help find solutions to some very pressing problems facing the health care system.

Thank you for your consideration.

DATE March 7, 1995

SENATE COMMITTEE ON Joint Select Committee on Health Care

BILLS BEING HEARD TODAY: HB 511, HB 542, SJR 14,
HB 405, SB 405, HB 531, HB 560

< ■ >

PLEASE PRINT

< ■ >

Check One

Name	Representing	Bill No.	Support	Oppose
JACK MOLLOY	MONT HEALTH CARE AUTH			
M. Swanson	HEAL. MT	HB 560 HB HB 505-53	X	
Keith Karns	Montana Association of Health CARE PURCHASERS	HB/SB 405		X
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS	HB/SB 405		
Ed Copley	MS CA	HB 531 : HB 560		
FRANK COTE	ST. Auditor			
Claudia Clifford	State Auditor's Office			
Ed Groman	MMBP/MAPT			
Tom Hoppood	Health Ins. Assoc. Am.			
David Owen	MT Chamber			
Robert Turner	MT Dept of Revenue			
TOM EBZEVY	Yellowstone Comm Health Plan			
Riley Johnson	NFIB			

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

DATE March 7, 1995

SENATE COMMITTEE ON Joint Select Committee Health Care

BILLS BEING HEARD TODAY: HB 511, HB 542, SJR 14, HB 405,
SB 405, HB 531, HB 560

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PLEASE PRINT

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Check One

Name	Representing	Bill No.	Support	Oppose
<i>Joita Bennett</i>	<i>Molteno Logging Assoc</i>	<i>HB 531</i> <i>560 405</i>	☒	☐
<i>Dean M. Sandbach</i>	<i>NASA Auto Parts</i>	<i>HB 531</i> <i>560 405</i>	☒	☐
<i>Charles R. Brooks</i>	<i>Billings Chamber</i>	<i>HB 405</i> <i>HB 511</i>	☒	☐
<i>Laurie Ekanger</i>	<i>Governors Office</i>	<i>HB 405</i> <i>HB 511</i>	☒	☐
<i>Tanya Azk</i>	<i>Blue Cross Blue Shield</i>	<i>HB 405</i> <i>SB 405</i> <i>HB 511</i>	☐	☒
<i>Eve Franklin</i>	<i>S.D. 21</i>		☐	☐
<i>Jerin T. Loeudt</i>	<i>Art Rep Assoc</i>	<i>HB 531, HB 560</i> <i>HB 405, SB 405</i>	☒	☐
<i>Keith L. Colbo</i>	<i>Deaconess - Billings</i>	<i>HB 405</i>	☒	☐
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VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

ROLL CALL

[illegible]

AMENDMENT TO HB-531DISCLOSURE BY INSURERS

1. Page 7, Line 30.

Following: "(7)"

Strike: Line 30 through page 8, line 16.

Insert: "A health care insurer shall provide to any person, upon request, a general history of the cost of its various health benefit plans which are currently filed with and approved by the commissioner pursuant to 33-1-501. Such general history shall include the trend of cost increases or decreases over at least the preceding 5 years, if available, for each of such health benefit plans."

2. Page 21, Line 17.

Following: "(4)"

Strike: Line 16 through page 22, line 4.

Insert: "A health care insurer shall provide to any person, upon request, a general history of the cost of its various health benefit plans which are currently filed with and approved by the commissioner pursuant to 33-1-501. Such general history shall include the trend of cost increases or decreases over at least the preceding 5 years, if available, for each of such health benefit plans."

-END-

EXECUTIVE ACTION ON HB 531Discussion:

Rick Hill said they had amendments.

CHAIRMAN BENEDICT said they have taken a lot of things out of the bill to put them into other areas that they have already discussed. They will have the provider disclosure language and they have some amendments for that.

Motion/Vote:

REP. ORR MOVED the amendments. (EXHIBIT #9) The MOTION CARRIED UNANIMOUSLY.

Discussion:

CHAIRMAN BENEDICT they have taken all of the provisions out of the bill besides disclosure and they would have to decide how they wanted to handle provider disclosure. There are going to be two sets of amendments.

SEN. FOSTER said (EXHIBIT #10) was being passed around and he did not know if they other amendments were complementary.

Susan Fox said that EXHIBIT #9 deals with 17-19 in a completely different way that EXHIBITS #10 & #11 do. EXHIBITS #10 & #11 are similar, but competing and EXHIBIT #12 is a complementary amendment to EXHIBIT #11.

Motion:

SEN. FOSTER MOVED the amendments on EXHIBIT #10.

Discussion:

SEN. FOSTER said those amendments were agreed upon by all of the interested parties. He said it was discussing the consumer reports card. In the new section it was speaking to the Department of Social and Rehabilitation Services working with the other interested parties to design a consumer report card. He said he would like to have the Montana Health Care Advisory Council appoint a task force to do that. Currently there is no such thing to do that so on page 2, it says if HB 511 was passed then it would supersede SRS doing that. If HB 511 did not pass SRS would do that. He said the reason that "quality of care" was crossed out because there was not an answer to do that. He said that was a positive thing for the consumers and it would give the providers a chance to look at different ideas. He said on page 2, under the new section 21, was listing the members on the task force and the term "health care providers" was not included and

should be. He asked as a policy matter, should they have Legislators on that task force.

SEN. JACOBSON said that was a valid effort on the part of people. She said they were trying to set up a situation to provide data to people without an adequate data base, without adequate reporting and they would get other paper that others were not using. The Health Care Authority was going to set up a uniform data base and have uniform billing. Until they get uniform billing the data that they are getting is so un-uniform that it would not be very useful to anyone. She said that was premature.

SEN. FOSTER replied that was correct. He said by using the terms uniform data and others in the amendment they were saying they are going to have to figure out uniform data. The task force would have to address that.

CHAIRMAN BENEDICT said that the bill did not mandate those things right now. It says that the task force would figure out how to get uniform data.

SEN. JACOBSON asked how much money were they giving them to do that. The biggest piece of the Governor's budget that was turned down in the SRS budget was the formation of the data base. She said they were putting out a task to be done with no funding and that is why she was objecting.

SEN. FOSTER said they could not have a data base unless they know how they are going to get to uniformity. Once that is determined then they can move forward.

CHAIRMAN BENEDICT said that the advisory is structured so that they would be coming back to the legislature with a report prepared for the 1997 legislature which will may be include funding for the data base because they will know how the data base was needed to be set up.

SEN. JACOBSON said at the end it said "The Montana Health Care Advisory Council shall submit the task force's proposal to prepare the consumer report card by October 1, 1996."

CHAIRMAN BENEDICT replied that was going to be how to structure it.

REP. SIMON said that the Montana Health Care Authority had money in their budget to design a data base. They were told that they would be working on designing the data base and not developing a data base.

SEN. ECK said she would rather have them continue planning than to drop it. There has been some work done.

Vote:

The MOTION CARRIED with SEN. JACOBSON voting no.

Motion:

REP. SIMON said that his amendments were no longer necessary.
(EXHIBITS #11 & #12)

Discussion:

SEN. FOSTER asked if they wanted to have the legislators on the task force.

CHAIRMAN BENEDICT said they voted on the amendments of the bill that stripped everything on the bill.

Susan Fox said that if they wanted the amendments in EXHIBIT #10 to override just those sections that they adopted in the amendments of EXHIBIT #9.

David Niss said that was going to be the effect of them.

Motion/Vote:

SEN. FOSTER MOVED to add legislators to be members of the task force. The MOTION CARRIED UNANIMOUSLY.

Motion/Vote:

SEN. FOSTER MOVE HB 531 DO PASS AS AMENDED. The MOTION CARRIED UNANIMOUSLY.

EXECUTIVE ACTION ON HB 376

Discussion:

CHAIRMAN BENEDICT said there were amendments proposed by the State Auditor's Office and the MEWA's.

Gary Spaeth explained the amendments. (EXHIBIT #13)

Motion:

SEN. JACOBSON MOVED the amendments. (EXHIBIT #13)

Discussion:

JOINT SENATE-HOUSE SELECT COMMITTEE ON HEALTH CARE

ROLL CALL

DATE 3-16-95

[illegible]



HOUSE STANDING COMMITTEE REPORT

March 17, 1995

Page 1 of 2

Mr. Speaker: We, the committee on Joint Select Committee on Health Care report that House Bill 531 (first reading copy -- white) do pass as amended.

Signed: 
Steve Benedict, Chair

And, that such amendments read:

1. Title, lines 4 through 14.

Strike: "RELATING TO" on line 4 through "DATES" on line 14

Insert: "PROVIDING FOR THE DESIGN OF CONSUMER REPORT CARDS ON
HEALTH CARE SERVICES"

2. Page 1, line 18 through page 26, line 6.

Strike: everything after the enacting clause

Insert: "

NEW SECTION. Section 1. Consumer report cards. (1) The department of social and rehabilitation services shall, in cooperation with consumers, employers, health insurers, hospitals, health care providers, and legislators, design a consumer report card that will enhance consumer responsibility in the use of health care services.

(2) The department of social and rehabilitation services shall, by October 1, 1996, submit to the legislature a proposal that contains the information needed to prepare the consumer report card. The information must include:

(a) uniform data, including charges, that will enable consumers to evaluate the cost of medical procedures;

(b) data about insurance plans, such as benefit and cost provisions;

(c) additional information that may assist consumers in making informed choices about their medical care; and

(d) any further applicable information generated as a result of efforts undertaken pursuant to 50-4-502.

Committee Vote:

Yes 10, No 0.

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(3) The department of social and rehabilitation services shall also develop standards for uniform data to be provided by health insurers, hospitals, and health care providers and shall take into account the feasibility and cost-effectiveness of the standards.

(4) To the extent possible, data collected for the consumer report card must be provided by data sources that currently exist."

NEW SECTION. Section 2. Codification instruction. [Section 1] is intended to be codified as an integral part of Title 50, chapter 4, and the provisions of Title 50, chapter 4, apply to [section 1].

NEW SECTION. Section 3. Coordination instruction. (1) If House Bill No. 511 is passed and approved, [section 1(1)] must read as follows:

"(1) The Montana health care advisory council shall appoint a task force of consumers, employers, health insurers, hospitals, health care providers, and legislators to design a consumer report card that will enhance consumer responsibility in the use of health care services."

(2) If House Bill No. 511 is passed and approved, the first sentence of [section 1(2)] must read as follows:

"(2) The Montana health care advisory council shall, by October 1, 1996, submit the task force's proposal to the legislature containing the information needed to prepare the consumer report card."

(3) If House Bill No. 511 is passed and approved, [section 1(3)] must read as follows:

"(3) The Montana health care advisory council shall also develop standards for uniform data to be provided by health insurers, hospitals, and health care providers and shall take into account the feasibility and cost-effectiveness of the standards."

-END-

Insurance Reform Testimony
Rick Hill *exhibit one*
March 16, 1995

The issues surrounding small group reform and the Small Employer Health Insurance Availability Act go beyond one bill. The amendments I will present and explain deal with five bills:

- HB446 -- preexisting conditions
- HB466 -- small group insurance reform revisions
- HB531 -- general reform proposal
- HB533 -- general health plan revision and individual insurance market reforms
- SB341 -- Montana Comprehensive Health Association revisions

The amendments address five general areas within small group and general health insurance market reforms:

1. Benefit design
2. Reinsurance program
3. Conversion coverage
4. Disclosure/Comparison information
5. Montana Comprehensive Health Association

The issues were addressed with the intent of providing more affordable health care benefit options in the individual and group markets.

The amendments strengthen the Small Group Availability Act to address concerns that the cost of guaranteed issue is being borne solely by the small group market. They allow comparison of one uniform product from insurer to insurer. They provide a guaranteed price for a leaner benefit conversion plan, providing comparable disclosure information from one insurer to another when a consumer is shopping for health insurance, and they enhance the benefits for folks who are served by the Montana Comprehensive Health Association.

I will deal with amendments one bill at a time, but first I need to explain the health benefit plans which run throughout several of these bills. We started with the current Montana Comprehensive Health Association benefit plan, and separated it into two parts, actual benefits and financial criteria or insured financial responsibility, which means deductibles, copayment levels, lifetime maximums and the like.

Benefit Plan Explanation

An outline of all the benefit plans is attached to the testimony for your information.

Uniform Benefit Plan -- The Uniform Benefit Plan must be made available to all individuals and all groups (of 3-25 employees) by health insurers and HMOs. This plan will be non-guaranteed issue, and is designed as a low cost catastrophic benefit plan for individuals, and for small groups who want to be subject to underwriting standards.

Financial criteria for this product:

- 50/50 copayment after a \$1,000 deductible per individual,
- \$2,000 per family with a one million dollar lifetime maximum benefit.

Contract benefits for this product:

- hospital and physician services
- a limited prescription drug benefit.
- Rehabilitative services and a number of other (medical) goods and services are covered
- Transplants, if needed, up to \$150,000 in a lifetime, plus \$10,000 for donor costs.

When people who will buy this type of policy think about covering health care costs, they are thinking about the emotional and financially catastrophic events. A transplant clearly falls in that category.

The traditional mandated benefit of psychiatric and chemical dependency is not included in this benefit design, just as it is not included in the Montana Comprehensive Health Association coverage. All other mandated benefits have also been removed for the purpose of designing this low cost benefit plan, which can be medically underwritten. Again, remember this is catastrophic coverage.

The requirement that the Uniform Plan must be made available is part of the amendments to HB533. This plan is also referenced in HB466.

Montana Comprehensive Health Association Plan – the Montana Comprehensive Health Association is a high risk pool established by the 1985 Legislature to provide health insurance for individuals, who, because of health history or conditions, could not obtain private health insurance.

The current level of benefits are enhanced under this package proposal to provide coverage for listed transplants, again with a lifetime benefit of \$150,000. The Association board of directors is given the latitude to design a lower cost plan by varying the financial cost sharing arrangements with the insureds. At a minimum, the board will still provide a plan which contains the current financial cost of a \$1,000 deductible with 80/20, but the maximum lifetime benefit for that option has been moved to \$500,000.

The enhancement of the MCHA plan has been moved from HB531 into SB341 so it fits with other modifications proposed by the Association board.

Basic Health Benefit Plan – Under the provisions of small group reform one standard benefit plan and at least one basic health benefit plan must be made available on a guaranteed

issue basis by all insurers writing small group insurance. The basic benefit plan approach was substantially modified from current administrative rules to allow, again, for the development of lower cost options.

Insurers may offer more than one basic plan, which is any plan with a lower level of benefits than the standard plan.

Financial criteria – the insurer may offer various levels of deductibles, copayment and other cost sharing arrangements.

Benefits – the basic benefit plans must contain at least the uniform plan benefits plus the mandated mental health/chemical dependency mandate plus the conversion mandate. Insurers can then add other benefits over and above these specific services and articles (such as medical supplies and equipment) as are requested by the marketplace, designing products to fit what the marketplace can afford.

Standard Health Benefit Plan – All insurers writing coverage in the small group marketplace must provide, on a guaranteed issue basis, a standard plan which provides a greater level of benefits than basic plans.

Financial criteria – at least 75% of the covered expenses of the standard plan must be paid after a maximum deductible of \$500 per person or \$1,000 per family. Annual out of pocket expenses cannot be more than \$2,000 per person or \$4,000 for a family with not less than \$1,000,000 lifetime benefit under the standard plan.

Benefits – the standard plan must include all of the benefits in the uniform plan plus the required benefits of the basic plan plus all other state mandates. Additional services and articles may be covered.

Both the basic and standard benefit modifications are contained in the amendments to HB 466.

Next, I would like to address what the five sets of amendments accomplish.

Amendments Overview

The amendments to HB466:

1. Redefine the basic and standard health benefit plans, both as they were set forth under the Insurance Commissioner's administrative rules and as proposed in the introduced HB466. These are the two types of guaranteed issue plans which will be offered in the small group marketplace. Definitions have been added to simplify the method whereby an HMO certifies that its plans are basic and standard. Clarification of the mandate waiver in 33-22-1821 is made as to which mandated benefits apply to which plans.
2. All language laying out a single guaranteed issue Uniform Plan and the Alternate Contingency language has been removed.
3. The reinsurance program has been rewritten to assure spreading the cost of guaranteed issue beyond the small group marketplace. The changes clearly address concerns that the cost of this reform could be borne solely on the backs of small business. At the beginning of each year the reinsurance board is to project the cost of the potential claims to the reinsurance pool. Fifty percent of that cost is to be built into the cost of the reinsurance premium paid by the small employer insurer buying the reinsurance. The other fifty percent will be paid through a premium all health insurers, health service corporations, HMOs excess and reinsurers pay based on their Montana business in the previous year.
4. Some associations provide health benefit plans to their employer members. Many association members are small employers. Association benefit compliance with the guaranteed issue requirement is clarified to fit with the same number of eligible employees as does small group reform.
5. One amendment allows insurers who were in the market prior to small group reform and who do not wish to now write new small group business to continue servicing existing clients from three to seven years. They must, however, comply with small group reform requirements for those clients. They also cannot write new groups, nor can they rewrite existing groups on new policies.
6. One amendment clarifies that employees who pay the full cost of their individual coverage through a flex benefit plan mechanism are not subject to small group reform.

House Bill 446 -- preexisting condition reform

1. Lowers the number of years an insurer can look back to determine preexisting conditions. Current law allows five. The change will now allow for only a three-year look back.

2. Clarification is made for disability income insurance to allow for conditions manifesting themselves during the first twelve months of coverage.
3. Clarifies the use of elimination riders, a mechanism whereby insurers can cover a person with a specific health condition which normally would preclude that person from getting insurance. The insurer riders out that condition, and accepts the individual for all other health conditions or incidental injuries. This has been standard practice in the marketplace, but only recently the Insurance Department said the practice was not allowed. Therefore, this amendment clarifies what has been standard practice.
4. Retroactive applicability — important because riders have not previously been specifically addressed in Montana law, but have been an industry practice not precluded by Montana law for a number of years.

House Bill 531 — Medisaves, Basic Plan Design, information, etc.

The amendments to this bill remove all sections but the information reporting requirements on health care facilities and providers. All other provisions are addressed in other bills, with the exception of Section 6 — standardized claim form. That provision has been addressed for insurers through administrative rule by the Insurance Commissioner. The Health Care Advisory which is being created by HB511 should continue to pursue this for other payors, where it has jurisdiction.

House Bill 533 — health benefit plan revision, preexisting waiver portability

1. In addition to the individual market reforms contained in this bill, insurers and HMOs will now be required to meet certain insurance product disclosure standards for prospective applicants. These standards will allow comparison of benefits, financial requirements like deductibles, potential price and underwriting characteristics, and general premium trend information. (Amendment 3, New Sections 5-7)
2. The Uniform Benefit Plan which all insurers will be required to make available to individuals and groups on an underwritten basis is defined in Amendment 3, New Sections 8-10.
3. Conversion — for the past 14 years, individuals who leave a group insurance plan have had the right to convert to individual coverage on a guaranteed issue basis without preexisting condition applicability. The conversion right has now been expanded to include conversion to the lowest cost Basic Plan at 150% of the highest rate for that plan.

Senate Bill 341 — Montana Comprehensive Health Association

The MCHA board had recommended some statutory changes to the current benefit plan, and has also expanded benefits where they have been able to do so. The amendments:

1. Enhance current MCHA benefits by adding coverage for listed transplants and several other services.
2. Give the board flexibility to provide more than one level of benefits, so long as it continues to offer the current \$1,000 deductible, 80/20 plan with an expanded lifetime maximum of \$500,000.

I can tell you from first-hand experience that this has been a grueling, time-consuming, high intensity level process by which we have reached consensus on each of these issues.

Each party has had to give considerable ground from their original positions on any number of issues.

I believe the people of Montana have been well served by the process. We have made substantial improvements in the small group insurance market as well as expanding reforms in the individual market and insurance industry as a whole.

Now that we have dealt significantly with insurance issues, I hope when you return in 1997 we can focus as much time and energy on cost issues which will continue to be at the forefront of health care and our ability to purchase insurance and health care services.

BENEFIT DESIGN**Uniform:**

Group and Individual
Nonguaranteed Issue

Financial Criteria:

- (a) Pay 50% of the covered expenses in excess of an annual deductible that does not exceed \$1,000 per person or \$2,000 per family;
- (b) Include a limitation of \$5,000 per person or \$7,500 per family on the total annual out-of-pocket expenses for services covered; and
- (c) Be subject to a maximum lifetime benefit of \$1,000,000.

Benefit Criteria:

Covered expenses must include the following medically necessary services and articles when prescribed by a physician or other health care provider as designated in the contract:

- (a) hospital services;
- (b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;
- (c) use of radium or other radioactive materials;
- (d) oxygen;
- (e) anesthetics;
- (f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3) (c) (i);
- (g) services of a physical therapist;
- (h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;
- (i) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth or in connection with TMJ;
- (j) rental or purchase of durable medical equipment, which must be reimbursed after the deductible has been met at the rate of 50 percent, up to a maximum of \$1,000;
- (k) prosthetics, other than dental;
- (l) services of a licensed home health agency, up to a maximum of 180 visits per year;
- (m) drugs requiring a physician's prescription that are approved for use in human beings in the manner prescribed by the United States Food and Drug Administration at the rate of 50 percent, up to an annual maximum of \$1,000.
- (n) medically necessary, nonexperimental organ transplants of the following major organs, limited to a maximum of \$150,000 in a lifetime, with an additional \$10,000 to be paid for costs associated with the donor:
 - 1. kidney
 - 2. pancreas
 - 3. heart
 - 4. heart/lung
 - 5. lung

- 6. liver
- 7. high-dosage chemotherapy/bone marrow transplantation
- 8. cornea
- (o) pregnancy, including complications of pregnancy;
- (p) newborn infant coverage as provided in 33-22-301, 33-22-504, and 33-30-1001, MCA;
- (q) sterilization;
- (r) immunizations;
- (s) outpatient rehabilitation therapy;
- (t) foot care for diabetics;
- (u) services of a convalescent home, as an alternative to hospital services, limited to a maximum of 60 days per year; and
- (v) travel, other than transportation provided by a licensed ambulance service, to the nearest facility qualified to treat the patient's medical condition when approved by the insurer's Medical Utilization Review Department.

BASIC

Small Group and lowest cost for conversion
Guaranteed Issue

Financial Criteria:

Lower than standard, determined by marketplace

Benefit Criteria:

Uniform Benefit Plan

Mental Health/Chemical Dependency

Conversion

Plus whatever else marketplace determines up to standard

STANDARD

Small Group
Guaranteed Issue

Financial Criteria:

- (a) The minimum benefits must be equal to at least 75% of the covered expenses in excess of an annual deductible that does not exceed \$500 per person or \$1,000 per family.
- (b) The coverage must include a limitation of \$2,000 per person or \$4,000 per family on the total annual out-of-pocket expenses for services covered.
- (c) The coverage may be subject to a maximum lifetime benefit, but such maximums, if any, must not be less than \$1,000,000.

Benefit Criteria:

Uniform Benefit Plan

Plus all state mandates

Plus any additional benefits an insurer may decide to offer

MONTANA COMPREHENSIVE HEALTH ASSOCIATION

State-Sponsored High-Risk Pool for Individuals

Guaranteed Issue

Financial Criteria:

- (a) Pay at least 50% of covered expenses in excess of an annual deductible with \$1,000 annual deductible.
- (b) Limitation of \$5,000 annual out-of-pocket expenses for services covered.
- (c) Maximum lifetime benefits of at least \$100,000--the current level is \$350,000.
- (d) One option must be offered with coverage for 80% of the covered expenses required by this section in excess of an annual deductible that does not exceed \$1,000 per person. This association plan must provide a maximum lifetime benefit of \$500,000.

Benefit Criteria:

New benefits added to those already in plan are:

- a) Drugs requiring a physician's prescription that are approved for use in human beings in the manner prescribed by the United States Food and Drug Administration, covered at 50% of the expense up to an annual maximum of \$1,000;
- b) Medically necessary, nonexperimental transplants of the kidney, pancreas, heart, heart/lung, lung, liver, cornea, and high-dosage chemotherapy/bone marrow transplantation, limited to a lifetime maximum of \$150,000, with an additional benefit not to exceed \$10,000 for expenses associated with the donor;
- c) Pregnancy, including complications of pregnancy;
- d) Newborn infant coverage, as required by 33-22-301;
- e) Sterilization;
- f) Immunizations;
- g) Outpatient rehabilitation therapy;
- h) Foot care for diabetics;
- i) Services of a convalescent home, as an alternative to hospital services, limited to a maximum of 60 days per year; and
- j) Travel, other than transportation provided by a licensed ambulance service, to the nearest facility qualified to treat the patient's medical condition when approved by the insurer's Medical Utilization Review Department.

Amendments to House Bill No. 531
First Reading Copy

Requested by Sen. Benedict
For the Joint Select Committee on Health Care

Prepared by David S. Niss
March 16, 1995

1. Title, lines 4 through 10.

Strike: "RELATING TO" on line 4 through "PLAN;" on line 10

2. Title, line 11.

Strike: "INSURERS AND"

3. Title, lines 12 through 14.

Strike: "AMENDING" on line 12 through "DATES" on line 14

4. Page 1, line 18 through line 20 on page 20.

Strike: sections 1 through 16 in their entirety

Renumber: subsequent sections

5. Page 20, line 22.

Strike: "17 through 19"

Insert: "1 and 2"

6. Page 20, lines 24 and 25.

Strike: subsections (1) and (2) in their entirety

Renumber: subsequent subsections

7. Page 20, lines 26 and 27.

Strike: "health care provider" on line 26 through "hospital." on line 27

Insert: "person who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or the practice of a profession. The term does not include a hospital."

8. Page 21, line 1.

Strike: "Insurers and health"

Insert: "Health"

9. Page 21, line 2.

Strike: "Insurers, hospitals,"

Insert: "Hospitals"

10. Page 21, line 16 through line 4 on page 22.

Strike: subsection (4) in its entirety

11. Page 22, lines 6 through 14.

Strike: section 19 in its entirety

Renumber: subsequent sections

12. Page 23, line 1 through line 18 on page 25.
Strike: sections 22 and 23 in their entirety

Renumber: subsequent sections

13. Page 25, line 20.
Following: "Sections"
Insert: "1 and"
Strike: "through 6 and 17 through"

14. Page 25, line 21.
Strike: "19"

15. Page 25, line 22.
Following: "[sections"
Insert: "1 and"
Strike: "through 6 and 17 through 19"

16. Page 25, lines 23 and 24.
Strike: subsection (2) in its entirety

Renumber: subsequent subsections

17. Page 25, lines 25 and 26.
Strike: "20"
Insert: "3"

18. Page 25, lines 27 and 28.
Strike: "21"
Insert: "4"

19. Page 26, lines 4 through 6.
Strike: section 26 in its entirety

Amendments to House Bill No. 531
First Reading Copy

Requested by Representative Scott Orr
For the Joint Select Committee on Health Care Issues

Prepared by Susan Byorth Fox
March 16, 1995

1. Title, lines 10 through 12.

Following: "PLAN;" on line 10

Strike: the remainder of line 10 through "PERSON;" on line 11

Insert: "CONTINGENTLY PROVIDING FOR THE DESIGN OF CONSUMER REPORT
CARDS ON HEALTH CARE SERVICES;"

Strike: "PROVIDING PENALTIES;" on line 12

2. Page 20, line 22 through page 22, line 30.

Strike: sections 17 through 21 in their entirety

Insert: "

NEW SECTION. Section 17. Consumer report cards. (1) The department of social and rehabilitation services shall, in cooperation with consumers, employers, hospitals, insurers, and health care providers, design a consumer report card that will enhance consumer responsibility in the use of health care services.

(2) The department of social and rehabilitation services shall submit a proposal that contains the information needed to prepare the consumer report card to the legislature by October 1, 1996. The information must include:

(a) uniform data, including charges, that will enable consumers to evaluate the cost of medical procedures ~~and the quality of care;~~

(b) data about insurance plans, such as benefit and cost provisions;

(c) additional information that may assist consumers in making informed choices about their medical care; and

(d) any further applicable information generated as a result of efforts undertaken pursuant to 50-4-502.

(3) The department of social and rehabilitation services shall also develop standards for uniform data to be provided by insurers, hospitals, and health care providers and shall take into account the feasibility and cost-effectiveness.

(4) To the extent possible, data collected for the consumer report card must be provided by data sources that currently exist."

Renumber: subsequent sections

3. Page 25, lines 20 and 21.

Following: "6"

Strike: the remainder of line 20 through "19" on line 21

4. Page 25, line 22.

Following: "6"

Strike: "and" through "19"

5. Page 25, lines 25 through 28.

Strike: lines 25 through 28 in their entirety

Insert: "(3) [Section 17] is intended to be codified as an integral part of Title 53, and the provisions of Title 53 apply to [section 17]."

6. Page 25, line 29.

Insert: "

NEW SECTION. Section 21. Coordination instruction. (1)

If House Bill No. 511 is passed and approved, [section 17(1)] must read as follows:

"(1) The Montana health care advisory council shall appoint a task force of consumers, employers, hospitals, and insurers, to design a consumer report card that will enhance consumer responsibility in the use of health care services."

(2) If House Bill No. 511 is passed and approved, the first sentence of [section 17(2)] must read as follows:

(2) The Montana health care advisory council shall submit the task force's proposal that contains the information needed to prepare the consumer report card to the legislature by October 1, 1996."

7. Page 26, line 4.

Strike: "24, 25"

Insert: ", 20 through 22,"

8. Page 26, line 6.

Strike: "23"

Insert: "19"

Amendments to House Bill No. 531
First Reading Copy

Requested by Representative Simon
For the Joint Select Committee on Health Care Issues

Prepared by Susan Byorth Fox
March 16, 1995

1. Page 1, line 15.

Insert: "WHEREAS, the Department of Social and Rehabilitation Services is charged with developing a consumer report card to enhance consumer responsibility in the use of health care services; and

WHEREAS, an important element of cost data for hospitals is actual charges; and

WHEREAS, any hospital data included in a consumer report card should include actual charge data."

Amendments to House Bill No. 531
First Reading Copy

Requested by Representative Simon
For the Joint Select Committee on Health Care Issues

Prepared by Susan Byorth Fox
March 15, 1995

1. Title, lines 10 through 12.

Following: "PLAN;" on line 10

Strike: the remainder of line 10 through "PERSON;" on line 11

Insert: "PROVIDING FOR THE DESIGN OF CONSUMER REPORT CARDS ON
HEALTH CARE SERVICES;"

Strike: "PROVIDING PENALTIES;" on line 12

2. Page 20, line 22 through page 22, line 30.

Strike: sections 17 through 21 in their entirety

Insert: "

NEW SECTION. **Section 17. Consumer report cards.** (1) The department of social and rehabilitation services shall, in cooperation with consumers, employers, hospitals, insurers, and health care providers, design a consumer report card that will enhance consumer responsibility in the use of health care services.

(2) The department of social and rehabilitation services shall submit a proposal that contains the information needed to prepare the consumer report card to the legislature by October 1, 1996. The information must include:

(a) data that will enable consumers to evaluate the cost of medical procedures and the quality of care;

(b) data about insurance plans, such as benefit and cost provisions;

(c) additional information that may assist consumers in making informed choices about their medical care; and

(d) any further applicable information generated as a result of efforts undertaken pursuant to 50-4-502.

(3) The department of social and rehabilitation services shall also develop standards for data to be provided by insurers, hospitals, and health care providers and shall take into account the feasibility and cost-effectiveness.

(4) To the extent possible, data collected for the consumer report card must be provided by data sources that currently exist."

Renumber: subsequent sections

3. Page 25, lines 20 and 21.

Following: "6"

Strike: the remainder of line 20 through "19" on line 21

4. Page 25, line 22.

Following: "6"

Strike: "and" through "19"

5. Page 25, lines 25 through 28.

Strike: lines 25 through 28 in their entirety

Insert: "(3) [Section 17] is intended to be codified as an integral part of Title 53, and the provisions of Title 53 apply to [section 17]."

6. Page 25, line 29.

Insert: "

NEW SECTION. Section 21. Coordination instruction. If House Bill No. 511 is passed and approved, [section 17(1)] must read as follows:

"(1) The department of social and rehabilitation services shall, in cooperation with the Montana health care advisory council, consumers, employers, hospitals, and insurers, design a consumer report card that will enhance consumer responsibility in the use of health care services.""

7. Page 26, line 4.

Strike: "24, 25"

Insert: ", 20 through 22,"

8. Page 26, line 6.

Strike: "23"

Insert: "19"

3-16-95

CONSENSUS AMENDMENTS**House Bill 531****March 16, 1995****Joint Number Select Health Care Committee**

1. Page 1
Line 4 through line 10
Following: "AN ACT"
Delete: "RELATING TO" through "INSURANCE ASSOCIATION PLAN;"

Line 11
Delete: "INSURERS AND"

Line 12
Following: "PENALTIES;"
Delete: "AMENDING SECTIONS" through line 13 "33-22-110, MCA;"
2. Page 1, Line 18 through page 20, line 20
Delete: Sections 1 through 16
3. Page 20, lines 24 and 25
Following: "(1)"
Delete: "Health benefits plan" through "in 33-22-125"
Re-number subsequent sections
4. Page 21, Line 1
Following: "Section 18."
Delete: "Insurers and"
5. Page 21, line 2
Delete: "Insurers"
6. Page 21, line 16 through page 22, line 4
Delete: Subsection (4) in its entirety
7. Page 22, lines 6 through 14
Delete: Section 19 in its entirety
8. Page 23, lines 1 through page 25, line 18
Delete: Sections 22 and 23
9. Page 25, lines 20 through 24
Following: "(1)"
Delete: "[Sections 2 through 6" through "apply to [sections 7 through 13]"

10. Page 26, line 4

Following: "[Section "

Delete: "13,"

Line 6

Following: "[Sections "

Delete: "1 through 12 and 14 through 23]"

Insert: "18, 20, and 21"

201TA316.1H

Exhibit #
3-16-95

Pondera Medical Center

406-278-3211 805 Sunset Blvd. Conrad, MT 59425

TO: Representative Bruce Simon
Joint Select Committee on Health Care

FR: Carl Hanson, Administrator *Carl*

RE: HB 531

Regarding HB 531, I have two concerns that I hope you will keep in mind as you consider this bill. The first is the experience of other states that have attempted such disclosure. The second is the value of the price information to the consumer.

OTHER STATE'S EXPERIENCE

Several other states have attempted such programs of disclosure. When Utah enacted such laws, they found that the primary users of the data were other physicians and hospitals. Their interest in the information was not so much to ensure their own competitiveness, but to figure out ways to charge more for certain items. You or some of the Committee members might investigate Utah's experiences with charge disclosure.

VALUE OF PRICE INFORMATION

For as long as I can remember, this hospital has provided price information in advance to any patient who requests as much. Pondera Medical Center has found that a list of prices, or a "charge master," does not mean much to the patient. The structure of the document is based upon Medicare and Medicaid codes. It is difficult to interpret. Other states have proven that the data this bill will make available has been important only to other providers and insurance companies.

What has proven valuable to the patient is the average discharge cost for the type of procedure being considered, and the extremes that have been experienced for that procedure in the last six months. This information has been, and will be, provided to any inquiring patient.

I hope the legislature does not enact a law to require what is already being given in an understandable form to anyone who asks.